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ARE CDC'S PRIORITIES RESTORING PUBLIC TRUST

AND IMPROVING THE HEALTH OF THE AMERICAN PEOPLE?

TUESDAY, JULY 23, 2024

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 11:16 a.m. in Room 2322 of the Rayburn House Office Building, Hon. Larry Bucshon [vice chair of the subcommittee] presiding.

Present: Representatives Guthrie, Burgess, Latta, Griffith, Bilirakis, Bucshon, Carter, Dunn, Crenshaw, Joyce, Balderson, Harshbarger, Miller-Meeks, Obernolte, Rodgers (ex officio); Eshoo, Sarbanes, Cardenas, Ruiz, Dingell, Kuster, Kelly, Barragan, Craig, Schrier, Trahan, and Pallone (ex

officio).

Also present: Representative Schakowsky.

Staff Present: Grace Graham, Chief Counsel, Health; Sidney Greene, Director of Operations; Emily King, Member Services Director; Chris Krepich, Press Secretary; Molly Lolli, Counsel; Emma Schultheis, Clerk; Lydia Abma, Minority Policy Analyst; Shana Beavin, Minority Professional Staff Member; Tiffany Guarascio, Minority Staff Director; Una Lee, Minority Chief Health Counsel; and Caroline Oliver, Minority Intern.

*Mr. Bucshon. [Presiding] The Subcommittee will come to order.

The chair recognizes himself for five minutes for an opening statement.

Welcome to all our witnesses. Today we are here to assess the effectiveness over the past several years of key centers within the Centers for Disease Control and Prevention.

With an agency that receives nearly $20 billion in annual funding and plays a critical role in assisting our states and localities with preparedness and response efforts, it is essential for Congress to evaluate the job the CDC is doing to achieve its mission. I still believe today the CDC is the preeminent organization in the world for the role that they play. The agency's mission states that it is designed to "work 24/7 to protect America from health safety and security threats, both foreign and in the United States. To accomplish our mission, CDC conducts critical science and provides health information that protects our nation against expensive and dangerous health threats, and respond when they arise."

To know and fully understand the CDC's mission is to realize the history of the agency. Originally established in 1946, the CDC -- in effect, an extension of the Department of Defense, and created -- and was created to help track malaria internationally. Today the agency operates 23 different centers, institutes, and offices that all have different focuses. We will hear from the directors of six of these centers today about their role in executing the CDC's mission and their vision for the future.

Since the COVID-19 pandemic hit our shores, Americans have experienced historic rises in drug overdoses fueled by a tragic rise in illicit fentanyl being trafficked across our southern border -- China, Mexico, into the United States. Overdose prevention remains one of the CDC's core responsibilities, but data show rising year over year overdose rates and indicating the overdose prevention efforts require some scrutiny. This includes whether Federal overdose prevention and response efforts can be streamlined across agencies to help better direct resources to communities most in need.

The nation now faces potential -- now potentially faces

a threat with the H5 avian influenza, which is impacting poultry and dairy farms, and has infected 10 farm workers across the United States. While the avian influenza does not currently present imminent harm to humans, my hope is that CDC learned some lessons, as we all did, through COVID-19, and will be adequately prepared to respond if needed.

The CDC received over $1 billion in direct funding for a data modernization initiative that has yet to bear fruit. There are outstanding questions about how the funding is being utilized -- how much is being utilized, and for the purposes it is being utilized. The agency continues to seek additional data authorities, despite operating over 100 surveillance programs and skepticism around the authorities they already have from the American people, including in my district. We need strong answers to justify why these authorities are needed.

While I do give the agency a lot of credit for taking the steps towards much-needed reform and reorganization, I do believe continued increased reflection is needed, particularly for an agency that technically remains unauthorized. The American people deserve a CDC that is

accountable to its core mission: preparedness and response to infectious diseases. Otherwise, we risk repeating past failures and placing millions of Americans' lives at stake.

[The prepared statement of Mr. Guthrie, delivered by Chair Guthrie's designee, Vice Chair Bucshon, is as follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. I yield. I now recognize the gentlelady from California, Representative Eshoo, for five minutes for an opening statement.

*Ms. Eshoo. Thank you, Mr. Chairman, and good morning, colleagues. It is an honor to welcome six leaders from the CDC this morning. I think it is the very first time that we have had the CDC Centers' directors together for a hearing. So my thanks to each of you, and welcome again.

Since its founding over 80 years ago, the CDC has grown to be, as the chairman just said, the preeminent health agency in the world. It is the first responder to dangerous outbreaks around the globe, a leader in cutting-edge research, and the foundation for our nation's public health infrastructure. The CDC is the largest Federal source of funding for state and local public health and prevention programs -- I think there are many, many members that don't realize that -- with over 80 percent of the funding we provide to the CDC distributed directly to state and local public health programs. So when the CDC is strong, so are our communities strong.

Yet there is, I think, a serious mismatch between our

public health investment and our nation's public health needs. The U.S. spends more than $4.5 trillion and $14,000 per capita on health care in 2022, but only $19 per person on public health. The pandemic exacerbated this mismatch. Congress poured tens of billions of dollars into the CDC and local public health, but since then budgets have been slashed. These boom and bust cycles, where we overspend during an emergency and underspend to improve basic biosecurity tools, leave our data systems and public health workforce fragile and unprepared.

The current House appropriations bill to fund the CDC for 2025 continues this trend by cutting the agency's funding by $1.8 billion, a 22 percent reduction from the previous year.

The bill also eliminates key CDC programs that our constituents rely on, including the Center for Injury Prevention and Control, home to programs that protect women, children, and families from domestic abuse, sexual violence, and gun violence; ending the HIV Epidemic Initiative, which aims to reduce new HIV infections by 90 percent by 2030; and initiatives to prevent chronic disease and improve children's

health. Over 160 medical and public health organizations oppose these cuts because they would severely weaken our public health infrastructure and put millions of Americans at risk.

Public health, I think, has become a casualty of partisanship. For example, over a year ago the bipartisan Pandemic All-Hazards Preparedness reauthorization bill -- we have an abbreviation for it, it is PAHPA -- fell apart because the majority chose to ignore the hollowed-out public health system and underfund key CDC programs.

Our nation has a shortage of 80,000 public health workers, and we are collecting public health data about outbreaks via fax machines and scraps of paper. We have set up the CDC in our local public health agencies to fail, and PAHPA has still not been reauthorized. I am the original author of that legislation. I feel, obviously, very strongly about it.

Strengthening Public Health has been my North Star over my entire tenure in Congress, so I look forward to hearing from the center directors today about how we can move the CDC forward and not backward, because the American people deserve

only the best.

[The prepared statement of Ms. Eshoo follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. With that I thank you, Mr. Chairman, and I yield back.

*Mr. Bucshon. The gentlelady yields back. I now recognize the chair of the full committee, Chair Rodgers, for five minutes for an opening statement.

*The Chair. Thank you, Vice Chair Bucshon. Good morning to my colleagues, and welcome to our witnesses.

For decades America enjoyed its status of having one of the preeminent public health infrastructures in the world. Federal agencies conducted cutting-edge research and facilitated private-sector efforts to advance science and keep our citizens safe. Then the COVID-19 pandemic struck. The CDC was established to assist states and localities in controlling infectious disease outbreaks. COVID-19 should have been the agency's moment to shine. Unfortunately, on almost every level, the CDC fell flat. From egregious flaws in testing, confusing and at times blatantly misleading communications mishaps, and one-size-fits-all guidance and mandates, the CDC failed at its primary job of helping states and localities detect, respond to, and control a disease outbreak.

These failures begged the question: Why did the CDC fail to execute its principal mission at the time of most need?

Was it because the agency's focus had strayed too far from its core mission?

Is the agency spread too thin across competing and misguided priorities?

And how do we refocus the agency to most effectively meet the needs of the American people?

It is notable that between fiscal years 2013 and 2014, non-communicable disease funding increased by 150 percent. Over that same period there has been consistent increases in the rates of chronic diseases such as diabetes, obesity, and hypertension. There is clearly a disconnect here.

Congress has a responsibility to understand what the return on the investment has been. As the committee responsible for overseeing the CDC, we must question the effectiveness of these programs, understand who at the CDC is responsible for evaluating these programs, and whether these investments would be better directed elsewhere.

The unfortunate truth is that Americans have lost the

faith in their public health agencies, especially in the CDC. The agency's many failures rightfully led people to question whether the guidance being released was actually grounded in science, reason, or even common sense. As our committee helped to uncover, the six-foot social distancing rule just kind of appeared, as Dr. Fauci put it. More recently, Dr. Fauci attributed the decision to mandate the six-foot social distancing rule entirely to CDC. And yet, the CDC has failed to explain how it was coming to its conclusions during that time, who was making these decisions, why it was issuing such guidance, and how that guidance would keep people safe.

The CDC failed to explain how our understanding of the science evolved and changed over time. And the CDC failed to offer any kind of nuance as to who was vulnerable and who wasn't. These failures led to massive learning loss for our children that set them decades behind, a mental health crisis, and economic hardship.

We need the CDC to be successful and credible for the health and future of our nation, but there is a lot of work that needs to be done to restore people's trust. Late last year we held a hearing with the director of CDC, Dr. Cohen.

At that hearing we heard updates on the CDC-wide Moving Forward Initiative. We likely have differing opinions on how productive and effective that initiative has been and the outcomes it has generated. However, I think that that initiative does show that we all agree that work must be done to rebuild public trust in the CDC and our public health institutions.

That work will only be successful if the CDC's leadership and your centers and offices are truly committed to reform, and are willing to show you can make hard decisions that need to be made. That means admitting where inefficiencies exist, and taking accountability for mistakes. It means being honest about what you know and do not know and when you know it. It means making honest attempts to streamline and perhaps, in some cases, eliminate programs that are no longer working for the American people. And it means showing the American people you value their judgment, their individual perspectives, and that you are committed to regaining their trust.

My hope is that we can work together to achieve this, starting with today's conversation.

[The prepared statement of The Chair follows:]

**********COMMITTEE INSERT**********

*The Chair. Thank you, and I yield back.

*Mr. Bucshon. The gentlelady yields back. I now recognize the ranking member of the full committee, Mr. Pallone, for five minutes for an opening statement.

*Mr. Pallone. Thank you, Mr. Chairman.

The Centers for Disease Control and Prevention is recognized domestically and globally as the leading public health authority. And today we will hear from six center directors at the CDC on the critical role the agency plays in both domestic and global public health. And I thank our witnesses, who are all career public servants, for being here today.

This hearing comes at a time when House Republicans continue their extreme partisan assault on the CDC. It never used to be this way. Democrats and Republicans used to work together to strengthen the CDC so it could confront the public crisis of the future.

And it is important to remember that, since its inception, the CDC's mission has always been focused on improving the everyday lives of all Americans. In 1946 CDC began its work with a primary mission to prevent malaria from

spreading across the U.S. With a budget of only $10 million and fewer than 400 employees, the agency built a public health infrastructure to prevent the spread of malaria, and that work has continued ever since. During the 1950s it was the complete elimination of malaria from the United States. In the 1960s and 1970s, CDC led the way in establishing a national tuberculosis surveillance system and spearheaded rubella vaccinations. In the 1980s, 1990s and 2000s, the CDC established the HIV Aids Awareness and Prevention campaigns, tobacco cessation programs, the Worldwide Polio Eradication Initiative, and identification of the novel H1n1 virus.

Now, today the CDC conducts critical science monitoring and health guidance to protect our nation against dangerous health threats, including the recent COVID-19 pandemic and ongoing opioid crisis. In fiscal year 2023, CDC processed more than 25,000 grants and cooperative agreements to support state, county, and local public health programs. These programs save lives and Federal and state health care dollars, and CDC's work has significant health and economic benefits that work to improve the well-being of the American people and to lower overall health care spending.

And these programs are making a difference in all of our districts. In my state, for instance, the CDC has provided over $325 million in grant funding for projects ranging from Safe Women Infant Health at the New Jersey Health Department to critical worker safety programs at Rutgers University. And yet House Republicans continue to cave to the extreme elements in their party by proposing massive CDC funding cuts and the total elimination of some programs. Earlier this month the House Appropriations Committee passed a partisan fiscal year 2025 Labor/HHS funding bill that includes a $1.8 billion cut in funding from last year for the CDC. And these shortsighted actions threaten the progress we are making to rebuild our nation's public health infrastructure.

House Republicans support major cuts to programs that address firearm injuries, opioid overdose prevention, suicide prevention, tobacco prevention, and HIV prevention. Imagine that. Last year more than 107,000 Americans died of a drug overdose. This is still a national crisis. And yet House Republicans are looking to cut the opioid overdose prevention and surveillance program by $560 million below last year's funding levels. To me, that defies logic when we all

recognize that this opioid crisis continues. And they also threaten boots-on-the-ground programs and local health departments in the communities that we all serve.

So there is no doubt that we should always be looking for ways to strengthen our Federal agencies. But unfortunately, House Republicans are continuing their attempts to hamstring CDC's ability to fulfill its mission. They have failed to reauthorize the Pandemic All-Hazards Preparedness Act, they repeatedly misled the American people about the efficacy of vaccines, and now they are undermining the CDC with an 18 percent cut in funding.

And if that is not bad enough, Republicans are pushing Trump's Project 2025 a blueprint for a potential second Trump Administration that proposes eliminating the independence of agencies like CDC. Trump's Project 2025 is a plan to consolidate power in the White House and get check -- and gut checks and balances to the harm of the American people.

And Trump's Project 2025 would undermine public health preparedness and lead us vulnerable and unprepared for future public health emergencies. It is the way for the extreme right wing to take control of our Americans' lives and our

freedoms, and it is not the path we should be taking. We should be looking to strengthen the CDC for the future, not weaken it. A robust investment in the CDC and its diverse array of programing is vital to America's health and well-being, and our leadership position around the world.

[The prepared statement of Mr. Pallone follows:]

**********COMMITTEE INSERT**********

*Mr. Pallone. So I look forward to the testimony today, and I yield back, Mr. Chairman, the balance of my time.

*Mr. Bucshon. The gentleman yields back. I will now recognize all of our witnesses for today: Dr. Henry Walke, director of the Office of Readiness and Response; Dr. Jennifer Layden, director of the Office of Public Health Data, Surveillance, and Technology; Dr. Daniel Jernigan, director, National Center for Emerging and Zoonotic Infectious Diseases; Dr. Karen Hacker, director, National Center for Chronic Disease Prevention and Health Promotion; Dr. Demetre Daskalakis, director, National Center for Immunization and Respiratory Diseases; and Dr. Allison Arwady, director, National Center for Injury Prevention and Control.

Dr. Walke, I first recognize you, and recognize you for five minutes for your opening statement.

STATEMENT OF HENRY WALKE, M.D., M.P.H., DIRECTOR, CDC OFFICE OF READINESS AND RESPONSE (ORR); JENNIFER LAYDEN, M.D., PH.D., DIRECTOR, CDC OFFICE OF PUBLIC HEALTH DATA, SURVEILLANCE, AND TECHNOLOGY (OPHDST); DANIEL JERNIGAN, M.D., M.P.H., DIRECTOR, CDC NATIONAL CENTER FOR EMERGING AND ZOONOTIC INFECTIOUS DISEASES (NCEZID); KAREN HACKER, M.D., M.P.H., DIRECTOR, CDC NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION (NCCDPHP); DEMETRE DASKALAKIS, M.D., M.P.H., DIRECTOR, CDC NATIONAL CENTER FOR IMMUNIZATION AND RESPIRATORY DISEASES (NCIRD); AND ALLISON ARWADY, M.D., M.P.H., DIRECTOR, CDC NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL (NCIPC)

STATEMENT OF HENRY WALKE

*Dr. Walke. Chairs Guthrie and McMorris Rodgers, Ranking Members Eshoo and Pallone, and distinguished members of the committee, it is an honor to appear before you today to discuss how CDC is protecting health and improving lives. I am Henry Walke, the director of CDC's Office of Readiness and Response.

My colleagues and I are here to discuss CDC's three main priorities: improving readiness and response, improving mental health and preventing overdose and suicide, and supporting young families. To tackle this critical set of priorities that are foundational to all of our health, CDC needs sustained and increased resources and authorities from Congress to help improve CDC's core capabilities in data and analytics, laboratory capacity, a public health workforce that reflects the communities we serve, and domestic and global readiness and response.

The mission of the Office of Readiness and Response is to lead and coordinate the agency's response to public health threats at home and abroad. To achieve this mission we work to prepare CDC and the nation to respond to all public health threats and, once a public health threat is detected, to put our readiness and response capabilities into action at CDC, alongside our state and public health partners.

I would like to highlight some specific ways that our work directly enhances CDC's core capabilities and ways we have changed to meet today's public health challenges. CDC is focused on making actionable data available for decision-

making at all levels of public health.

The Office of Readiness and Response supports world-class data through the Response Ready Enterprise Data Integration platform, otherwise known as REDI, a data modernization success story for how CDC can access, use, and share actionable public health data. REDI pulls data from a wide variety of sources together in one common operating picture, and enables users at all levels of government as well as academia and healthcare to analyze, visualize, and share that data in real time during a public health response. The platform has fast-tracked data modernization improvements for programs and responses, allowing CDC to collect and analyze data at an unprecedented scale, turning data into action more quickly than ever before.

Also housed within the Office of Readiness and Response, the CDC's newly-established Center for Forecasting and Outbreak Analytics, which generates forecasts and scenario models to extract as much information as possible from the data made available by REDI and other sources to deliver actionable information and guide decision-makers as they take actions to protect their communities.

Our new CDC Ready Responder Program ensures that our multi-disciplinary workforce is trained before a public health event, and are ready to respond when and where needed. My team in the Office of Readiness and Response is made up of incredibly dedicated individuals who work around the clock to protect your health.

But we need the entire agency to be able to respond to any health threat that comes our way. We are currently managing 4 infectious disease responses that involve over 500 staff using this new system. This ability to surge staff and to respond faster than ever before represents a significant improvement over how CDC operated prior to COVID, and is a key example of how CDC is breaking down silos, leveraging and surging our public health workforce, and prioritizing readiness and response.

We are also working to enhance state, tribal, local, and territorial health departments' response capabilities and readiness through the Public Health Emergency Preparedness, or PHEP, program. The PHEP program is a critical source of funding, guidance, and technical assistance for public health departments nationwide. PHEP has the systems, the expertise,

and the relationships to continue strengthening America's readiness to respond to the next public health crisis. Like much of CDC's funding to public health departments, PHEP makes up the majority of resources that states and localities have to prepare for emerging threats, and it is important to prioritize sustained and increased resources for this work.

Finally, CDC is elevating response readiness science to improve how we evaluate our efforts, and implementing strategic priorities that are central to U.S. Government's efforts to maintain and strengthen biosafety and biosecurity practices in laboratories working with dangerous pathogens. CDC is working every day to achieve our priorities, but we know we can't do this alone. It will take continued collaboration with public health partners, other government agencies, and the private sector.

Critically, we also need support from Congress. All of us want our family and friends to be protected from health threats. That is CDC's job, and we work every day to achieve that mission. But we can't be the national security asset you need without supporting core capabilities and having the tools to get people and data responding to health threats

without delay.

I look forward to speaking with you today on the ways that we can enhance our collaboration to protect health and improve lives, and I am happy to answer your questions.

[The prepared statement of Dr. Walke follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. Thank you for your testimony. I now recognize Dr. Layden for five minutes.

STATEMENT OF JENNIFER LAYDEN

*Dr. Layden. Thank you. Chairs McMorris Rodgers and Guthrie, Ranking Members Pallone and Eshoo, and distinguished members of the committee, it is an honor to appear before you today. My name is Jen Layden, and I serve as the director of CDC's cross-cutting data office, which was established first in 2023 as the agency's first office dedicated to leading a comprehensive public health data strategy and our modernization efforts across the nation's public health data systems.

We have all witnessed the importance of timely information to protect our nation for detecting novel threats, recognizing the early signs of an outbreak, and enabling timely and efficient actions that save lives. Thanks to Congress's investments in data modernization, we are achieving faster, more actionable data so that health and governmental officials at any level can make informed decisions for their communities.

Strengthening the nation's readiness and response capacity is a CDC priority, and data modernization is at the

heart of that work. Each outbreak underscores our need to strengthen and sustain capacity for early warning of disease threats in real-time, situational awareness across all of our jurisdictions. CDC has a comprehensive agency and public, health-wide vision in which essential data can be exchanged securely and quickly. We work with and support all programs at CDC and, importantly, partner with many partners: our health departments, health care, and the private sector.

We have made tremendous progress in a very short amount of time. For example, we have seen exponential increases in the use of electronic case reporting nationwide, which allows public health authorities to receive critical information within seconds, a dramatic shift from the slow and burdensome manual reporting by fax, manual entry, and phone. Now more than 38,000 health care facilities across all 50 states leverage this technology, up from only 187 facilities before the pandemic. This allows faster threat detection, swifter action, and saves time by eliminating the need to hand-enter the data by our clinicians. Importantly, we are bringing this capacity to rural areas and tribal nations. Just this past year we have increased the number of critical access

hospitals with these capabilities by 78 percent.

Syndromic data is one of our nation's earliest signals of potential health threats. Thanks to data modernization, public health now captures more than 87 percent of emergency room visits across our nation. This capability allowed us to quickly determine that the concerning signals of pediatric pneumonia that we observed abroad this winter were not being seen here in the U.S.

Additionally, we are now releasing weekly provisional mortality data that used to take months to publish. This improves our nation's ability to detect concerning trends for all sorts of conditions, including opioid deaths and suicides.

CDC, thanks to Congress, has invested heavily in data modernization across our jurisdictions, the front line of public health. Prior to joining CDC, I worked at the state and local level of public health. I have experienced the challenges of under-invested data systems, and now I am seeing the impact and positive value of these investments in data modernization.

The core capability of data analytics is giving the

nation the situational awareness that it needs. For example, jurisdictions can inform their community now in real time of local trends like respiratory illnesses and toxic chemical exposures, and jurisdictions can more quickly understand maternal mortality trends and causes.

Even with these successes, there remains much work to be done. When data exchange is working well, we can detect threats and quickly intervene rapidly. When data exchange is incomplete or slow, information gets missed and our response is delayed, which means people get sick and more people die. Further progress depends on increase in sustained Federal investments to our core capabilities, enabling our nation to have the needed technology to rapidly detect novel health threats, provide state-of-the-art situational awareness, and communicate public health information to our communities.

Finally, technology alone cannot achieve this. CDC still relies on voluntary reporting across a fragmented public health data policy framework. Absent the ability to secure access -- securely access timely and standardized data, we continue to risk delays in detecting novel threats. Outbreaks do not stop at jurisdictional lines. CDC needs

updated authority to facilitate timely and standardized data so that our nation has the right data at the right time to respond to any threat.

Thank you for this opportunity to share what we are doing to protect Americans' health and improve lives, and I look forward to the conversation.

[The prepared statement of Dr. Layden follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. The gentlelady yields. I now recognize Dr. Jernigan, five minutes.

STATEMENT OF DANIEL JERNIGAN

*Dr. Jernigan. Chairs McMorris Rodgers and Guthrie, Ranking Members Pallone and Eshoo, distinguished members of the committee, it is an honor to appear before you today. My name is Dr. Dan Jernigan, and I serve as the director of the National Center for Emerging and Zoonotic Infectious Diseases at CDC.

I am honored to lead a team that works tirelessly to protect Americans from emerging infectious disease threats by preventing, detecting, and controlling diseases ranging from the common and routine, like foodborne and health care-associated infections, to the rare and fatal like Ebola and anthrax. Americans are safer because CDC responds to infectious disease threats using our world-class laboratories, our data for action, and our scientific experts. Enhancing these core capabilities is my top priority.

From Atlanta to Anchorage and in strategic locations around the globe, we prevent, identify, and investigate infectious diseases, drawing upon expertise on over 800

different pathogens that can cause illness and death like bacteria, parasites like malaria, viruses, and fungi. We maintain expert laboratories, including a high containment facility, to safely perform cutting-edge work to combat and contain the highest risk pathogens. Without these people and labs, we would not be able to develop more effective vaccines, therapeutics, and diagnostic tools.

CDC has refocused our work toward innovative, new approaches that have changed the way we do business like monitoring different pathogens in wastewater, detecting infectious diseases at airports through the traveler-based genomic surveillance, and using advanced molecular detection at all state health departments for tracking pathogens and antibiotic resistance in health care settings. We are grateful for congressional support for these efforts, and these are all capabilities that Americans now expect of their public health system. If we don't invest in them, we will lose them.

Importantly, we support all 50 state health departments through our Epidemiology and Laboratory Capacity cooperative agreement, or also known as ELC, which provides critical

support at the state and local level for detecting and controlling infectious diseases in their communities. This funding essentially keeps the lights on for many state infectious disease programs.

In 2024 ELC provided over $250 million to health departments for core infectious disease work. We live in a world that is becoming more crowded and connected. The worlds of people, animals, and agriculture are converging. This puts us at greater risk for infectious disease outbreaks. In an interconnected world, a person infected with a virus can travel from a forest in West Africa to a suburb in Dallas before any infectious disease symptoms appear. This is something that we absolutely saw firsthand in 2014 with Ebola.

At CDC we have learned a number of lessons over the last few years, and today you will hear how CDC needs strengthened investments in our cross-cutting, rapid response capabilities to stay ready for future threats. For my center this means funding approaches that are nimble and that can address many pathogens, such as emerging infectious diseases, advanced molecular detection, and antimicrobial resistance. We need

to have the capability to use our resources to tackle any emerging threat before it becomes an outbreak.

Recent years have made the threat of infectious diseases clearer than ever. Pathogens are relentlessly complex, and they don't respect borders. They constantly evolve, and they disproportionately burden the vulnerable. We can stay ahead of these threats and tackle them head on, but we need your support for increased and sustained resources for core capabilities and new authorities identified through our lessons learned.

So thank you for the opportunity to share the work my center is doing to save lives and protect Americans from health threats, and I look forward to your questions.

[The prepared statement of Dr. Jernigan follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. Thank you for your testimony. I now recognize Dr. Hacker, five minutes.

STATEMENT OF KAREN HACKER

*Dr. Hacker. Chairs McMorris Rodgers and Guthrie, Ranking Members Pallone and Eshoo, and distinguished members of the committee, it is an honor to address you today on the work CDC does to protect health and improve lives, including by preventing the nation's leading causes of death.

I am Dr. Karen Hacker, director of the National Center for Chronic Disease Prevention and Health Promotion, and I am privileged to lead this center full of dedicated experts that translate research into proven strategies that we can all use to prevent chronic health conditions.

CDC has been working with communities to understand and prevent chronic diseases for over 60 years. These diseases cause devastating effects on our lives. Cancer, heart disease, and diabetes are the leading causes of death and disability in our country, and 6 out of 10 Americans are living with at least one chronic health condition, and they account for 90 percent of our country's $4.1 trillion annual health care costs.

The successes of the chronic disease center are

evidenced every day when people receive timely preventive screenings and services to reduce maternal mortality or reduce disease risk factors like smoking, poor nutrition, or physical inactivity, and better manage conditions like diabetes, high blood pressure, and breast and cervical cancer.

Every year our center provides more than $800 million in support to your states and local communities. Our national programs in cancer, diabetes, heart disease, and smoking prevention have achieved enormous impact over the years at the national and state level. For example, beginning in 2010, CDC translated an NIH-proven intervention into a program that could be carried out at the community level. The National Diabetes Prevention Program became the first nationwide program proven to prevent or delay type 2 diabetes in adults through lifestyle changes, and program participants have reduced their risk by 58 percent. This is emblematic of CDC's role in making sure that investments in research are not left on a shelf, but are reaching our loved ones in our communities and allowing them to live life to their fullest potential.

Further, CDC's Colorectal Cancer Program partners with clinics and screened nearly 200,000 people for colorectal cancer in the last year. This was a 35 percent increase from the previous 12-month period, and we know that through screening we are saving lives.

And finally, our Tips From Former Smokers campaign has helped one million U.S. adults who want to quit successfully quit smoking, saving an estimated $7.3 billion in smoke-related health care costs. And our Empower Vape Free Youth campaign supports middle and high school educators with tools to talk about the risks of smoking e-cigarettes and nicotine addiction to help students avoid or quit vaping.

These programs and CDC's work have made meaningful progress over the past few decades, but we also saw a backsliding as a result of the pandemic. We saw delays and gaps in screening and management of diabetes, hypertension, and other chronic conditions. We saw reductions in physical activity and challenges with healthy eating, and we saw the devastating impact the pandemic can have on our loved ones that suffer from chronic diseases.

The Chronic Disease Center was a critical part of the

pandemic response, working together with our infectious disease colleagues to identify that obesity and diabetes were strong risk factors for COVID, and that COVID patients with severe hypertension were more at risk for hospitalization and 60-day mortality. And it is time to understand the breadth of these consequences and re-dedicate ourselves to funding and implementing prevention strategies.

As part of America's public health agency, CDC's Chronic Disease Center is uniquely focused on preventing the top killers of Americans, a role which no other Federal agency fulfills. Through CDC's core capabilities we use data and workforce to identify disease risk factors, burden, and trends that help us target evidence-based interventions, and we translate academic research to make sure our communities receive the benefits of that research. Complementary to our clinical delivery system, CDC works with communities to implement these evidence-based programs on a population scale to reduce health care costs and save lives.

So in closing, prevention is our strongest weapon against chronic diseases. And it not only saves health care costs, but it saves countless lives. But we can't do this

work alone. Just as we work with partners across government, non-profit, community-based organizations, we need help from Congress to continue to support sustained investments and authorizations that emphasize the importance of growing these programs.

Thank you for the opportunity to testify, and I look forward to answering your questions.

[The prepared statement of Dr. Hacker follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. Thank you for your testimony. I now recognize Dr. Daskalakis for five minutes.

STATEMENT OF DEMETRE DASKALAKIS

*Dr. Daskalakis. Chairs McMorris Rodgers and Guthrie, Vice Chair Bucshon, Ranking Members Pallone and Eshoo, and distinguished members of the committee, it is an honor to appear before you today. My name is Demetre Daskalakis, and I serve as the director of the National Center for Immunization and Respiratory Diseases, or NCIRD.

NCIRD plays a critical part in CDC's priorities of strengthening the nation's readiness and response capacity and supporting young families. Our immunization and respiratory disease efforts are supported by dedicated experts who work every day to protect the health and improve the lives of Americans. I have had the privilege to lead this team for the past year, and we have accomplished a lot together.

During the 2023/2024 respiratory virus season, CDC developed and executed a coordinated response to address the viruses that most frequently cause disease: COVID-19, influenza, and RSV. A core lesson from the pandemic was to improve communication, and we knew that this season was a

chance to show how we have improved. CDC provided clear, concise information for health care providers and the public to support informed decision-making to protect health and prevent severe illness.

Core to this strategy was effective information-sharing throughout the country. CDC traveled to communities and worked with trusted messengers to share the importance of immunizations against these viruses, and we created an easy-to-use dashboard where, for the first time, the public could see key indicators for COVID, flu, and RSV all in one place. Through continuous vaccine innovation, we were also able to expand the tools in our toolkit. In addition to new RSV vaccines to protect people over 60 years of age, as well as infants, the 2023/2024 season was the first time a monoclonal antibody was available to protect infants, young children, and their families from serious illness and hospitalization.

CDC responded nimbly to operational challenges when the demand for the new monoclonal antibody was higher than expected. As a result, for the first time, we were able to protect over 40 percent of newborns from RSV. This antibody proved critically important. Data from last season show that

it was 90 percent effective in preventing RSV-associated hospitalization in babies.

Underlying all of these efforts are CDC's advanced data systems that monitor disease trends and help inform effective public health responses to seasonal and novel outbreaks. These systems ensure timely and accurate information for both routine and emergent disease prevention efforts, strengthening our overall public health infrastructure and protecting our health security.

CDC's current response to highly pathogenic avian influenza, also known as H5N1, showcases the importance of these systems. When cattle were infected with H5N1, we swiftly scaled up human disease monitoring, leveraging partnerships with Federal, state, and local health departments. Since March 2024 over 1,500 people with exposure to infected cattle have been monitored. Since April 1 there have been 10 confirmed human cases of H5N1 in people exposed to these infected cattle or poultry.

CDC's Seasonal Influenza Surveillance System has also tested more than 32,000 specimens at public health labs across the country since March, using a protocol that can

detect this virus in the general population. If we are to continue this work, sustained increased investments in these core capabilities is essential.

In addition to disease preparedness and response, we are also engaged in CDC's priority to support young families. This year we celebrated the 30th anniversary of the Vaccines For Children, or VFC, program, one of the nation's most important public health achievements. VFC has ensured access to recommended lifesaving vaccines at no cost for over half of U.S. children. The program has prevented nearly 500 million illnesses, 1 million deaths, and saved over $2 trillion in societal costs.

However, there are still gaps in vaccination coverage. The pandemic disrupted routine immunizations, leaving children and their communities at higher risk for preventable infections. Approximately 250,000 kindergartners are not adequately protected against vaccine-preventable diseases such as measles due to ongoing vaccine hesitancy. This hesitancy has had tangible effects. This year alone we have identified 11 measles outbreaks and over 150 cases nationwide so far.

While VFC has demonstrated its effectiveness in children, no similar program exists in adults. We have had to build adult vaccine programs from scratch during COVID-19 without a permanent vaccine for adults program. The next time there is a vaccine-preventable outbreak, we will be back to square one.

CDC is applying lessons learned and changing how we operate by improving our communication and timeliness of data, but we can't do this alone. I look forward to working with you all on bipartisan solutions to support core capabilities and provide the authorities we need to safeguard the American public from new and emerging pathogens. Thank you.

[The prepared statement of Dr. Daskalakis follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. Thank you for your testimony. It is very much appreciated. I now recognize Dr. Arwady for five minutes.

STATEMENT OF ALLISON ARWADY

*Dr. Arwady. Chairs McMorris Rodgers and Guthrie, Ranking Members Pallone and Eshoo, distinguished members of the committee, it is an honor. My name is Dr. Allison Arwady, and I started as the new director of CDC's National Center for Injury Prevention and Control six months ago.

The Injury Center leads all of CDC's efforts across the country to prevent overdose, suicide, adverse childhood experiences, violence across the lifespan, and unintentional injuries from drowning to traumatic brain injuries and older adult falls.

I started my career working in public health infectious disease response as an internal medicine doctor and pediatrician. But in recent years I have increasingly focused on the public health response to injury topics like our country's overdose and suicide crises. Why? Because these are the threats that now kill most Americans in the first half of life and, as such, our top priorities for CDC because these deaths are preventable using the same data-driven approaches that public health has used to fight

infectious diseases over the last century. Because I love taking care of patients but I believe we cannot treat our way out of these crises one patient at a time, we simply must invest in the data-driven prevention work of public health.

As the nation's health protection agency, CDC protects health and improves lives. Overdose is the leading cause of death for Americans aged 18 to 44, and suicide is the second leading cause of death for Americans aged 10 to 34. In CDC's most recent National Youth Survey, 1 in 10 high school students reported that they had not just considered, but had attempted suicide. CDC's community-based population-level approaches to these crises complement the more clinically-based individual treatment focus of other Federal agencies.

CDC's Injury Center brings unique and unparalleled data systems, scientific and technical expertise, and strong collaboration and funding to every state health department and hundreds of local coalitions and organizations. More than 80 percent of the Injury Center's appropriations and 84 percent of our opioid funding is invested right into state and local partners across the country.

Our scientists track how threats are changing in near

real time because overdose threats can evolve as quickly as infectious disease pathogens. CDC labs distribute reference kits to ensure state laboratories can test for more than 1,300 emerging drug threats. In recent months CDC supported data systems, and epidemiologists across the U.S. have detected newer threats like the spread of Xylazine, the reemergence of carfentanyl, an analogue even more dangerous than fentanyl, and the doubling of deaths linked to counterfeit pills.

We then support public health departments and partners to use their local threat data to take action, ensuring the overdose reversal agent naloxone is available where overdoses actually occur, seamlessly connecting individuals and family members to treatment and support after non-fatal overdoses or suicide attempts and, critically, preventing these threats in the first place, with a special focus on adolescents.

Thanks to Congress, CDC invests hundreds of millions of dollars annually in 90 state and local health departments through our Overdose Data to Action program. We invest tens of millions more per year to ensure states can rapidly track and respond to changing local patterns in suicidal behavior

and other injuries, and we provide wraparound support and training for state and local public health departments. Already this year, the Injury Center has field-deployed expert teams seven times after states and tribes have requested extra assistance with acute local emergencies like new surges in overdoses or suicide clusters.

And there is hope. What we are doing is working, and we cannot stop that work now. Last year overdose deaths decreased nationally by three percent, the first decline in years. Our suicide prevention funding recipients focused on veterans, for example, saw a 5.8 percent suicide reduction in this critical population.

The Injury Center has protected Americans for more than 30 years by focusing on CDC's 4 core capabilities: data and analytics, lab capacity, public health workforce, and readiness and response. We continue to make progress and build trust. We must continue to collaborate across the Federal Government and communities.

An American has died from an overdose in the five minutes that I have been talking, and an American dies by suicide every 11 minutes. With help from Congress through

funding and authorities, CDC remains committed to using data to take action and save lives. Thank you.

[The prepared statement of Dr. Arwady follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. Thank you for your testimony. We will now begin questioning. I recognize myself for five minutes.

I just want to say at the outset immunization was mentioned. The Doc Caucus, including myself as a physician, during the pandemic led all kinds of efforts to promote vaccination by telling everyone to please talk to your doctor and individualize your medical case, why you should be vaccinated. I just want to say that because some people are mentioning that Republicans didn't support vaccination, and I don't think that was true. It was bipartisan, by the way.

I appreciate that we all share a commitment to restoring our trust in the nation's public health agencies. The response to COVID-19 somewhat damaged that trust. I think politics intervened, unfortunately. I do want to say again the CDC, in my view, is still the preeminent organization in the world for what they do. We now have to convince all of the American people that the CDC can rise to the occasion for the future. I believe we are on our way, but have worked to do.

As we have discussed, the CDC was established as an agency to focus on communicable diseases. But not all of you

have jobs that are clearly related to the mission of communicable diseases. I can appreciate that health threats have changed in the last 80 years, and the mission has evolved over time, but it remains a fact that the CDC is the primary agency tasked with focusing on preventing the spread of communicable disease, and I wonder if the agency has spread itself too thin.

COVID-19 showed us that infectious diseases are still very much a present danger to society. I encourage CDC leadership to focus on performing its core mission very well, and -- rather than trying to do a lot of things adequately.

Dr. Jernigan, I understand you served in the Epidemic Intelligence Service. For those who aren't familiar, the EIS is a program that currently operates a two-year fellowship at CDC. Its alumni have served as essential frontline workers in public health crises and communicable disease outbreaks. Currently, the average EIS class is around 60 to 64 graduates per year. To me, this seems like an under-investment when there is a widely recognized shortage of well-trained, qualified public health professionals. Fortunately, in its Moving Forward report, CDC suggested reallocating some of its

administrative and academic funds to training programs like EIS. With more positions, I would encourage CDC to provide more slots in state and local areas, and focus on establishing relationships with non-Federal frontline public health workers, and give the CDC real insight into the problems faced by these groups on the ground.

So Dr. Jernigan, what are your thoughts on expanding and/or reorienting EIS in this way?

*Dr. Jernigan. Thanks very much.

And so as an EIS officer -- and a number of us actually here went through that program -- it is an incredible program that really allows for there to be leadership at state health departments, leadership at CDC. And so we certainly support having that program completely supported so that it is able to provide those public health officials that are needed during crises, and so totally support the Epidemic Intelligence Service and continued funding for it.

*Mr. Bucshon. Thank you. This question kind of came up by Dr. Daskalakis's testimony about measles.

As you probably know, measles has not been an endemic in the United States for a long time. First, could you kind of

describe what endemic means, so that everybody understands that?

And are we at risk with vaccine reluctance in children to revisit measles being endemic in the United States of America?

*Dr. Daskalakis. Thank you so much for that question. So endemic means ongoing and sustained transmission in the U.S., and we have -- elimination means that we do not have sustained transmission of measles in the United States.

I think that the question is so relevant because we know measles vaccine is safe and effective. Two doses really prevents -- 95 percent protection from measles. We know that populations that are under-vaccinated are really the populations that are at risk. So the work that we do at CDC and NCI are to increase vaccine confidence, to remind people of the importance of childhood vaccination. It is lifesaving and also prevents measles on our shores.

*Mr. Bucshon. Yes, and would you estimate around the world the number of deaths per year from measles, childhood deaths?

*Dr. Daskalakis. I don't have the --

*Mr. Bucshon. Give me just an estimate.

*Dr. Daskalakis. Yes. I mean, it is on the order of thousands of deaths occur due to measles. And again, we are seeing -- you know, we live in a global scenario. And as we see measles increasing in other parts of the world, our best line of offense is really defense by making sure our population is adequately vaccinated.

And again, the good news is that we aren't seeing anywhere close to what we saw in the pre-vaccine era, but we have had ongoing outbreaks, over 150 cases. And actually, 57 percent of the cases in the last year were hospitalized. So again, emphasizing the importance of MMR vaccination and preventing this childhood illness.

*Mr. Bucshon. Yes, thank you for that. Thanks for that testimony. I have a serious concern about that around the country.

I yield back. I now recognize the ranking member of the Health Subcommittee, Ms. Eshoo, for five minutes.

*Ms. Eshoo. Thank you very much.

First I want to compliment each one of you. You gave excellent testimony. And what I like best about each

testimony is that anyone that is tuned into this hearing across the country could understand exactly what you do. And so this is -- you have just done a terrific job.

You know, we -- both the acting chairman and myself have made mention of 80 years, the CDC. But I think that we need to appreciate what has happened over 80 years. I mean, the population of the United States 80 years ago, 1944, we had 138,400,000 population in the United States. Today we are a population of 333.3 million people in our country. So that is almost triple the population. And with that tripling of a population and really being a global society today -- I mean, 1944, most people really didn't travel anywhere. Now the whole world is criss-crossing the globe on a consistent basis. So the challenges have changed enormously.

Dr. Arwady, in the current funding bill your center's funding is eliminated. Eliminated. That is pretty chilling after your testimony of what you do. And I especially appreciate your saying -- and I did not know this -- that overdose rates fell in 2023 for the first time in 5 years. So how is this -- what is going to happen with the elimination of your center?

*Dr. Arwady. It would be devastating for the work to prevent injuries and violence, including overdose and suicide, if this funding did not exist across the country.

*Ms. Eshoo. Is there any other place in the Federal Government under HHS where this is tended to?

*Dr. Arwady. So we work across the Federal Government. A problem this big, like opioids for example, requires multiple agencies. Our work at CDC is complementary. It is not duplicative. But at CDC, for example, it is our data systems that actually let us know what Americans are overdosing from today. It is the systems that let us have the real-time data. It is the systems that let us know how that threat continues to evolve. And importantly, it is the work that funds the frontline public health response to this threat.

*Ms. Eshoo. I hope that on a quiet basis that my colleagues on the other side of the aisle will talk to some of their colleagues in their caucus about what they have recommended in their appropriation bill, because I think that this is devastating. This is an issue that on both sides of the aisle members have been deeply, deeply concerned about,

and have experienced in their congressional districts, the number of deaths from overdoses.

Now, in public health -- and it is the case, I think, especially with AI now -- good data is gold, and good data helps to predict viral outbreaks, detect emerging trends in illicit drug use, track diseases in wastewater.

So to Dr. Layden, does the CDC have access to the health data it needs?

And if not, what prevents the CDC from getting that data? How do we fix it?

And another question: How do you respond to those who are concerned -- I think all of us are always concerned about how -- that data is used properly. There are some -- one of the concerns that has been raised by some members is how the CDC uses its data, and does it track people in their daily lives.

*Dr. Layden. Thanks for that important question. So a few things.

One, CDC in public health has been under-invested for decades. This has led to delays --

*Ms. Eshoo. It has.

*Dr. Layden. -- and gaps in the data that we need for national situational awareness and early threat detection.

We have seen the benefit and the impact, thanks to data modernization and COVID-related funds, over the last four years, tremendous progress in a very short amount of time, but there is more work to be done. We need continued and increased funding to ensure that not just CDC, but public health broadly can modernize the systems. The systems at the state and local level are the ones that collect the data, act on the front line, and then send the data to CDC. We need to --

*Ms. Eshoo. Oh, so it goes from the local to you.

*Dr. Layden. The vast majority of instances --

*Ms. Eshoo. Not the other way around.

*Dr. Layden. -- yes. Yes, so that continued sustained funding, with so much of our funds going out to the jurisdictions needed to ensure that we have these robust capabilities.

We also need data authorities. We do rely on voluntary reporting. That leads to a patchwork of the data that does come to CDC. So we -- when we want and need national

situational awareness and early threat detection, having that secure ability to receive that data so that we can act and support the nation and our communities is critical.

*Ms. Eshoo. Well, thank you again to each one of you. I am going to submit written questions to you.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. And I think that you have -- each of you has done a terrific job today.

I yield back, Mr. Chairman. Thank you for your patience.

*Mr. Bucshon. The gentlelady yields back. I now recognize Dr. Dunn for five minutes.

*Mr. Dunn. Thank you very much, Mr. Chairman, and thank you to the witnesses from CDC for appearing today. I appreciate the opportunity to examine how the CDC's priorities with their mission protect the health and safety of American people.

The agency's response to the COVID-19 pandemic was -- undoubtedly exposed some failures and shortcomings at the CDC, and that damaged the confidence of the American people in public health systems. And that happened, by the way, worldwide. Surely, a lot of that damage was caused by politics, but I think you could agree with me that public health should never be a politicized subject.

I am a doctor. As a former scientist at the Army Center of Biological Warfare and Chemical Warfare, I appreciate the important role CDC is charged with to effectively respond to

threats involving communicable diseases.

I am concerned that the CDC has become vulnerable to pressures, to effective political pressures to effectively focus on important emerging dangers. For example, the CDC, under the Environmental Public Health Tracking Network, operates something called the Environmental Justice Dashboard, which tracks factors like environmental quality, community design, and air quality. In my opinion, the program is at best duplicative with the EPA, and at worst it is just a waste of resources. It is little more than a distraction from the important work the CDC, I think, should be focusing on.

I also have concerns with how the CDC coordinates with other government agencies in the instance of an epidemic or pandemic like we had, agencies such as the FDA, ASPR at the HHS, NIH, and the White House, the Office of Preparedness that has been created. You know, I don't know if we can ensure that all of these agencies have clearly defined roles and responsibilities. In November I raised this concern with CDC Director Cohen, given the example of the illegal Chinese biolab discovered near Sacramento, California, and there was

a lackluster response to that, at best. They were putatively storing and experimenting with over 20 pathogens, including Ebola, HIV, SARS-CoV-2, and other dangerous diseases.

I am incredibly concerned that, without clearly defined roles in the agencies, when we face our next public health emergency our agencies will just be pointing the finger at each other again. Dr. Walke, can you explain how the Office of Readiness and Response works with the other agencies to ensure that the Federal Government is able to meet the next public health emergency with a coordinated effort?

*Dr. Walke. Yes, thank you for that question.

CDC does work with a number of different agencies on every response, whether it is the White House or across the interagency, with FEMA, with ASPR, with -- in this current HPAI outbreak with USDA. So we have a very robust coordination. For ASPR particularly -- in particular, we have a complementary role. ASPR is focused on, for example, medical countermeasure with BARDA development, and then distribution through the SNS to state and locals.

CEC, through its PHEP cooperative agreement, actually is really focused on state and locals' capacity to take those

medical countermeasures from warehouses, for example, and then get them into arms. And so they work on -- our CDC works on capabilities actually within state and local institutions. So that is our unique role here with our --

*Mr. Dunn. Let me just focus, if I can, just on the Reedley lab for a second. Who the heck should the sheriff have called when he found -- when that thing was discovered?

I remind you, it was discovered by a housing code inspector, and she talked to the sheriff. And the sheriff, he tried calling the FBI, the CDC, the FDA. He got no response from anybody. Who should he have called? Who is the right person to call for the next time that happens?

*Dr. Walke. Normally, within that situation, the City of Reedley and the state public health department would be the first to respond. We provide --

*Mr. Dunn. And they called the -- they -- state health said, "We are over our heads here, we need help,'' and they called the same people: FBI, CDC, everybody. Nobody came for months.

*Dr. Walke. They did call CDC. We talked with the California Department of Health. And at that time the

initial call was that they did not need help from our Federal Select Agent Program. We continued to converse with them, and then they requested assistance, actually, for an on-site investigation. We worked with the state and with the City of Reedley to actually -- and sent a team, and investigated that lab for about two-and-a-half days to look for --

*Mr. Dunn. Okay.

*Dr. Walke. -- any dangerous --

*Mr. Dunn. Who? Because we are running out of time, who does the sheriff call next time? Because he didn't get a response this time for months. I mean, people jabbering back and forth, but nobody showed up who actually has some wherewithal to take care of pathogens like that?

*Dr. Walke. Again, normally it would go through state and local government, but of course, our watch team with the Emergency Operations Center is on standby 24 hours a day, and certainly we would take that call --

*Mr. Dunn. Do you imagine that the states all have 50 little centers that can actually respond to something like that, a lab that is -- you know, this is a BSL-4-level crisis.

*Dr. Walke. Again, we have in every state, actually, the laboratory response network that actually have the ability through -- with the connection with CDC to test for dangerous --

*Mr. Dunn. Who -- well, I have exceeded my time, but I am going to submit this in writing, and I dearly want an answer.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Dunn. Who the heck gets called on this stuff? Because nobody responded from the Federal Government level to that state that was begging for help, and the state public health authorities were begging for help. The sheriff was begging. And it ended up the sheriff cleaning up the mess, which probably isn't a great idea.

I yield back.

*Mr. Bucshon. The gentleman yields back. I recognize Dr. Ruiz, five minutes.

*Mr. Ruiz. Thank you, Mr. Chairman. I would also like to thank the witnesses for being here today and for the important work you do to improve public health in our country.

CDC plays a vital role in protecting Americans from both infectious diseases and chronic illnesses, and we see this in CDC's priorities: its focus on tackling our nation's mental health crisis and the opioid epidemic, its work to improve maternal health outcomes and ensure children have access to lifesaving vaccinations, and its efforts to bolster the nation's readiness and response capacity to protect against future health emergencies. These are all critical functions

of the agency that Congress must continue to support.

As ranking member of the Select Subcommittee on the Coronavirus Pandemic, I believe it is critical to ensure the strength of our nation's public health and infectious disease workforce, infrastructure, and data to safeguard public health and prevent future public health emergencies.

Dr. Walke, can you share how your office supports states' and local health departments' readiness and response capacity?

*Dr. Walke. Yes, thank you for that question.

I want to say at the beginning that about 80 percent of our domestic CDC funding actually goes out to state and -- support state and local public health.

One of the ways that we support state and local health within my Office of Readiness and Response is through the Public Health Emergency Preparedness Program, which is the largest source of Federal funding for public health emergency preparedness, and actually CDC's largest domestic grant program. Recently we awarded over $650 million in 2024 to about 62 recipients, which included 50 states for large localities, and 8 U.S. territories and freely associated

states.

So the PHEP program got its start after 9/11, which demonstrated that public health departments lacked those critical systems for effective emergency response. And over the past two decades, PHEP investments have developed strong public health emergency preparedness programs, including Emergency Operations Centers, this ability that I spoke about to deliver lifesaving medical countermeasures, interventions to the public, shots into arms, and also nationwide laboratory and epidemiology surveillance systems.

Again, or in addition, we really focused on the public health workforce. And that PHEP program supports almost 6,000 state and local employees through that -- for public health and for emergency response.

*Mr. Ruiz. So what are your priorities moving forward, and how can Congress help you with those?

*Dr. Walke. Again, thank you for that question.

You know, we are really focused, actually, in my office on being able to detect an emerging threat, and whether that threat is an infectious disease or an environmental threat, as well, for example. And once we detect that threat, then

making sure that CDC and the nation actually can respond in a vigorous way. And one of the ways we do that, actually, is through supporting those core capabilities, and that is laboratory systems, that is the public health workforce. Those are those data modernization systems that we talked about.

And those emergency operation systems, the emergency management systems, both domestically and global -- so most of the -- or a number of the threats to the U.S., actually, are -- start overseas or abroad. And so we have over 60 country offices spread around the world that are also working with countries to detect those threats and keep those threats from coming to America's shores.

*Mr. Ruiz. And so what can Congress do to help you achieve those priorities?

*Dr. Walke. Again, we need sustained funding in order to maintain those core capabilities. We made incredible strides during COVID, but we are at risk of not being able to sustain those data modernization improvements, for example, or the public health workforce that were hired during COVID that actually were not able to keep going.

But one of the big issues is that we have this supplemental funding, boom and bust funding, whether it was Ebola or whether it was Zika and now COVID. And so we make strides, we make two steps forward, and then we have to take several steps back when that funding goes away. So we need sustained funding for those core capabilities, and we need those authorities, actually, whether it is with data or some workplace authorities in order to do the mission that we are assigned to do.

*Mr. Ruiz. Thank you. I look forward to continuing to support the work you all do at CDC every day to promote the health and safety of the American people and ensure our nation is equipped to respond to public health emergencies in the future. So thank you.

And I yield back my time.

*Mr. Bucshon. The gentleman yields back. I now recognized Mr. Latta from Ohio.

*Mr. Latta. Thank --

*Mr. Bucshon. Five minutes.

*Mr. Latta. Thank you, Mr. Chairman.

Our nation continues to face existential threats from

infections, viruses, and even poisoning from illicit and illegal narcotics. As we recently saw during the COVID-19 pandemic, how we address public health can drastically affect how we live and function in our daily lives.

As we look past the COVID-19 pandemic to possible threats on the horizon, I am concerned with the rise in Antimicrobial resistance, AMR. It is crucial the CDC takes action now to avoid potential catastrophic events. Data from the CDC shows that, globally, 1 person contracts an antibiotic-resistant infection every 11 seconds, and every 15 minutes someone dies. And an estimated 2.8 million Americans get antibiotic-resistant infections each year, leading to over 35,000 deaths. If no action beyond the current initiatives are taken, then given the global life expectancy will fall by 1.8 years over the next decade due to AMR.

Drug-resistant infections also create a substantial economic burden. The additional costs of treating resistant infections are estimated at $4.6 billion annually in the U.S. alone, due to factors like extended hospital stays and more expensive medications.

Studies show that only 30 to 50 percent of antibiotics

are prescribed appropriately. Dr. Jernigan, what more can be done to strengthen antibiotic stewardship, and how should we ensure that diagnostics are being fully utilized to improve the use of the last-line antibiotics?

*Dr. Jernigan. Yes, thank you very much. And I think, as you point out, antimicrobial resistance is a huge problem. It is something that is affecting globally, as well, as here in the United States, and we do risk at some point not being able to have antibiotics to treat routine infections or those really life-threatening infections, as well. The things that we are looking at, of course, working with BARDA and ASPR, and with others to have better antimicrobial drugs, antifungal drugs, antibacterial drugs, et cetera.

But those will take time. We may not even be able to find some of those. So we have to have other things that we are doing to make sure that we are preventing these antimicrobial resistant infections. One of those is infection prevention and control. So making sure that hospitals have the right way that they know how to control and keep these infections within those facilities and keep transmission from happening there.

Also, antimicrobial stewardship so that we give guidance and we have staff that are in facilities that know exactly what to choose based on what the antibiotic resistance pattern is within that facility. Better diagnostics, like you mentioned, so that we can see where is that AMR coming up, where is it happening.

And then for us, we are supporting state health departments and local health departments with funding so that they have those experts in IPC, the infection prevention and control, and antimicrobial resistance so that we are connecting health care and public health in a way that we have not done before so that we are actually addressing that problem of emerging antimicrobial resistance.

*Mr. Latta. Thank you.

Dr. Daskalakis, my district has the largest agricultural income producing district in the State of Ohio, and I am concerned about the impact AMR has on livestock. What is the CDC doing to address the impact of AMR and infectious diseases on livestock, particularly with the outbreak of avian flu and how its contagion can spread?

*Dr. Daskalakis. Though I will leave the AMR issue to

Dr. Jernigan, I can comment about the importance of the relationship between public health and agriculture in our response to highly pathogenic avian influenza.

So those relationships really, in that one health strategy that bridge public health and animal health, as Dr. Jernigan said in his testimony, are critical in being able to respond not only to sort of routine events, but also to events like highly pathogenic avian influenza. So we have some great models in states where, really, that close interaction means that farmers are being monitored, farm workers are being monitored, and appropriate testing is happening to identify cases.

I will yield the floor over to Dan to speak specifically about AMR.

*Dr. Daskalakis. Yes, just in terms of the -- in our center we have a one health office which actually looks at those issues that do cross agriculture, animals, and humans. Antimicrobial resistance is not just a human problem. We have to work very closely with our other Federal agencies and with industry to make sure that antimicrobials that are used for agriculture or animals are not going to lead us down a

path where we don't have those antimicrobials to treat infections in humans.

*Mr. Latta. Well, in my last 13, 14 seconds, real quickly, because, again, when I look at my district and you see what is happening, I mean, we are talking about millions of birds having to be destroyed. We are seeing, you know, going into different types of other herds out there, and also humans contracting.

What do you see, real quickly, on the horizon, how we can combat this?

*Dr. Jernigan. In terms of combating antimicrobial resistance in that --

*Mr. Latta. Right, and especially when you are talking about on the avian flu.

*Dr. Jernigan. I think the best thing we can do -- and I should yield back to --

*Mr. Latta. Well, if --

*Dr. Jernigan. -- Demetre, but --

*Mr. Latta. If the chair would --

*Mr. Bucshon. Sure.

*Dr. Jernigan. I just think surveillance for the

pathogens.

*Mr. Latta. Thank you very much.

*Mr. Bucshon. Go ahead and answer.

*Dr. Daskalakis. Thanks for that question.

So I think really sort of capitalizing on the one health strategy is really important, and so creating really good, good connections with farm workers, good connections with producers to make sure that as we identify animals we also are closely aligned with public health to make sure that we are monitoring workers.

I think we are collaborating very closely with our USDA colleagues who are providing really clear guidance in terms of strategies to address the on-the-ground events among animals and, again, our public health colleagues working closely to monitor the human health situation.

*Mr. Latta. Well, thank you very much. My time is expired, and I thank the chair.

Thank you.

*Mr. Bucshon. The gentleman yields back. I recognize Mr. Cardenas for five minutes.

*Mr. Cardenas. Thank you, Chairman Guthrie, and also

Ranking Member Eshoo for holding this hearing to discuss the work of the Centers for Disease Control and Prevention.

I also want to thank Doctor, Doctor, Doctor, Doctor, Doctor, Doctor --

[Laughter.]

*Mr. Cardenas. -- for being here today, and the work that you do on behalf of the American people every single day.

I want to begin by highlighting that this month was the 2-year anniversary of the launch of the 988 Suicide and Crisis Lifeline, the National Lifeline. The Lifeline has helped millions of Americans, and demonstrates a bipartisan, interagency commitment to meeting the mental health needs of those we represent. Historic investments in the successful transition to the lifeline have gone directly to states, territories, and tribes that have been diligently working to improve local response. Through these investments in improving capacity at call centers, expanding mobile crisis response, and developing stabilization facilities we can continue the vital work needed to overcome the crisis.

Despite the progress we have made in these last two

years, we continue to face immense challenges in addressing the mental health needs in our country. For example, a 2022 survey found that half of all adults nationwide had someone in their family that had experienced a severe mental health crisis. Over 13 million people reported seriously considering suicide, and over 1.5 million reported suicide attempts. The American people are counting on us to continue working to provide crisis care in these moments of crucial need.

It has been an honor to champion the 988 Lifeline and the crisis care continuum throughout my time in Congress. Through this work it has been continuously clear that we are only as strong as our ability to work together with our agency partners to address the nation's mental health crisis. As we look to address the full spectrum of care, this crisis demands a public health approach to suicide prevention and has proven critical to building, strengthening, and meeting Americans where they are.

Dr. Arwady, as we have heard, cuts to your center will affect your ability to carry out these proven public health interventions. For example, CDC is co-leading the 2024

National Strategy for Suicide Prevention and Federal Action Plan, which commits to a comprehensive, whole-of-society approach. So my question to you is, why is taking a public health-focused, comprehensive approach to suicide prevention important to our larger efforts to improve the mental health of all Americans?

*Dr. Arwady. Yes, thank you so much for that work and that question. As you say, a problem this big requires us to tackle it from all angles, and the public health approach is really thinking upstream about how do we recognize that not everyone who may be thinking about suicide or even attempting suicide is connected to a mental health provider.

The CDC funds -- it is called the National Violent Death Reporting System in every single state. And that is where we come to understand some of the risk factors related to suicide. So that is how we know which occupations, for example, may be at higher risk, or what other patterns that we see. And from that data we know that only about half of the people who tragically die by suicide have a diagnosed mental health condition. The other half, some have an undiagnosed mental health condition, but there are others who

this is an impulsive decision after a job loss, a relationship loss, some other acute issue in people's lives.

And it is so important, as our comprehensive suicide prevention program that we fund in about half of the states right now, works to make sure that we have folks outside of the medical system and before the crisis system who are trained to recognize the risks of suicide, to counsel folks, to get folks the skills that they need. So we are working with faith leaders, we are working with coaches, we are working with people who are not part of the medical system. But for a problem this big and this widespread, they -- that may be the first individual that someone is talking to.

So again, the work of public health in a prevention way and an upstream way really complements a lot of that crisis work and the individual treatment work that some other Federal agencies focus on.

*Mr. Cardenas. Thank you, Doctor. It is an all-hands-on-deck approach, and prevention and intervention early on is key.

Dr. Hacker and Dr. Arwady, could each of you briefly share how you are incorporating the improvement of mental

health outcomes into the work of your respective centers?

*Dr. Hacker. So hi, thank you again for that question.

At the Center for Chronic Disease in particular, we have been very interested in youth mental health issues. We are the center that has the Youth Risk Behavior Surveillance System, which is really the preeminent system that looks at youth self-perception, and that is where we often get our data on youth concerns about suicide, about attempts to have suicide, things like that, which Dr. Arwady already spoke about.

In addition, that -- it is called the Division of Adolescent and School Health has produced a toolkit for folks within education so that they have evidence-based practices to support young people within schools.

We are also looking at mental health relevant to things like diabetes, for example. We know there is a real overplay between having a chronic disease and also having mental health issues.

*Mr. Cardenas. Thank you.

My time has expired, Mr. Chairman. I will yield back.

*Mr. Bucshon. The gentleman yields back. I recognize

Mr. Bilirakis for five minutes.

*Mr. Bilirakis. Thank you, Doctor. I appreciate it very much.

Dr. Layden, the CDC has received at least $1 billion in designated funding for its data modernization initiative. With limited accountability for where the funding has gone, how much has been utilized and for what purposes?

The private sector has, again, simultaneously made tremendous strides in this space. But unfortunately, we have heard that CDC has not been willing to engage in leveraging private-sector innovation. Why isn't the private sector being leveraged and better utilized?

And what is the return on investment on the hundreds of millions of dollars we have invested in this particular space?

*Dr. Layden. Thanks for those questions --

*Mr. Bilirakis. Dr. Layden, please, thank you.

*Dr. Layden. Yes, yes, absolutely. Thanks for those questions. I will start with the investments to data modernization.

The first level -- first investment occurred in 2019,

with $50 million. The progress we have made in data and analytics across not just CDC but at our jurisdictional levels, is largely driven by COVID-related funds. Over the last 4 years we have been able to produce -- or provide 100 -- or $1 billion to our jurisdictional partners for data modernization. We have seen great and tremendous progress. We have seen examples of electronic case reporting, syndromic surveillance, vital statistics, cloud capabilities across our jurisdictions and at the CDC that is allowing us to have the robust national situational awareness.

To put it into context, over the last couple of decades $35 billion were provided to health care to modernize their health IT system. The amount of money that has gone to public health to modernize our system pales in comparison. Despite that, we have been able to make tremendous progress. And with continued and sustained funding, we will have the robust public health capabilities that our nation needs.

To your question about the partnership with private partners, that is critical for the work that we do, and we have multiple examples where not just CDC but our jurisdictional partners partner with private entities. We,

for example, over the last year, as we stood up the public health data office, we have had numerous summits where we have brought in private partners, the local, state jurisdictions, and CDC programs to all come together, talk about the needs that public health has, and create innovative solutions.

*Mr. Bilirakis. Well, thank you. If you could provide a written, detailed account of how this funding is being used again to our office, we would appreciate it very much. After the hearing, of course.

Dr. Hacker, the joint testimony mentioned the Diabetes Prevention Program which has been proven successful in preventing or delaying the onset of type 2 diabetes. The DPP is currently running unauthorized, along with many other CDC programs, which causes us on the committee to be concerned about the agency's transparency and accountability measures.

With over 38 million Americans living with diabetes, including myself, and its complications being the eighth leading cause of death nationwide, it is clear there are significant needs amongst our constituencies. How is the CDC consolidating its efforts?

And what metrics is it using to ensure the methods brought by the DPP are leveraged in state and local communities?

Please, again, this is for Dr. Hacker.

*Dr. Hacker. Thank you for that comment.

So the DPP program is, I think, one of our finest examples of a program that CDC -- where we used NIH data to develop a program that could be used at the state and local level. It is a national program, and we do fund all of the states to be able to implement the DPP program. Generally, we look to having community organizations that know folks within the community, they are well connected to the clinical system. This is a program that has been highly affected [sic], and it is really geared towards people who don't have diabetes yet, but may be at risk for developing diabetes.

And what we know is that, if you participate in this program -- and we know that this year alone there is something like 700,000 people who are actually participating in the program -- that they can reduce their risk of diabetes, actually getting diabetes, by over 50 percent. And after we have followed up -- because we do strong evaluation

to determine whether or not these programs continue to work, with which populations, where, how to deliver them -- what we have found is that even in looking back at these programs, people sustain those changes that they have made, and don't get diabetes.

So our space really is in the prevention of diabetes. Now, we are involved to some extent in the self-management of diabetes, and we do believe that there has not been enough focus on educating individuals with the disease on how best to manage themselves so that they don't end up with the terrible sequelae of the disease such as kidney problems or eye problems, things like that.

So while we look at our programs severely, we are really, really trying to make sure that what we are delivering -- and we do this also with our colleagues at the Centers for Medicaid and Medicare, because this is a program which is reimbursable, and we are very intent on making sure that the folks who need this program -- that they get the referrals from their clinical perspective, from their physicians, and that they actually engage in the program going forward.

*Mr. Bilirakis. Thank you.

My time has expired, Mr. Chairman --

*Mr. Bucshon. The gentleman yields back. I recognize Dr. Joyce, five minutes.

*Mr. Joyce. Thank you, Mr. Chairman, for holding this hearing today, and to our panel for testifying.

For the CDC to effectively execute its mission as a public health authority, the American people must trust that the information and the guidance coming from the agency is accurate, up to date, and based purely on the science of public health. As the directors, you must ensure that your center remains on mission and is in -- and is transparent and responsive both to the American public as well as to Congress.

As we examine the efforts of the CDC to rebuild their trust with the public, I want to delve into a few specific public health issues that fall within the scope of your centers. Dr. Arwady, recent studies by the CDC and NIH found that more than 50 million Americans suffer from chronic pain, back pain, shoulder pain, musculoskeletal disorders. The HHS Pain Management Best Practices Task Force has called for

individualized, multimodal care, improved access to non-opioid therapies, and increased education on pain management best practices.

Dr. Arwady, does the CDC support the task force recommendations?

And did the CDC's updated opioid prescribing guidelines incorporate those recommendations?

*Dr. Arwady. Thank you. So the experts who work on opioid prescribing at the CDC certainly work, again, across Federal Government, look at the data. And in the most recent update to the clinical guidelines for opioid prescribing, there was increased attention to making sure that folks' pain is being adequately addressed, including with alternate approaches.

One in nine Americans is still being prescribed an opioid every year, so we have continued work to do there. But there has been and continues to need to be additional work to ensure that folks with chronic pain are getting the relief that they need at the same time.

*Mr. Joyce. So the task force recommendations were included, incorporated with your recommendations as well? Is

this interaction occurring? That is my question.

*Dr. Arwady. So the experts who work on the clinical prescribing guidelines out from the CDC, again, are working across the Federal Government.

I will be honest with you, the -- this specific piece pre-dates my start with the Injury Center. I can follow up on the details --

*Mr. Joyce. I would appreciate that follow-up. I think that we all recognize, particularly with your data, that one in nine Americans are still receiving opioids annually in the United States. I think this is an important issue that we can work together on.

Continuing, Dr. Arwady, what educational tools has the CDC developed, and what are you doing to promote specifically non-opioid pain management options?

*Dr. Arwady. So this has been a major area of focus. We host calls that are focused on clinician education across the U.S. that routinely bring in thousands of individuals. We have developed materials and multiple pieces of guidance, as well as ensuring that when prescribers, physicians, but others as well, professional societies are meeting, they have

the updated guidance which has continued to put an emphasis on ensuring that those with chronic pain are also getting the attention that is needed.

So there has been a focus on education and the most recent updated guidelines from 2022 reflect more of that.

*Mr. Joyce. And I appreciate that focus on education.

Dr. Hacker, according to the CDC, approximately 2 million Americans have type 1 diabetes, which requires lifelong insulin. A simple blood test can detect the disease in its earliest stages. However, in those early stages, before insulin is required, those who test positive for associated autoantibodies can be monitored to help prevent diabetic ketoacidosis and be referred to medical interventions early to delay that onset.

I recently introduced H.R. 8698, the Screen for Type 1 Diabetes Act, with my colleague, Dr. Kim Schrier. This bill would create a public awareness campaign through the CDC on the benefits of early detection. Dr. Hacker, how would this bill enhance the CDC's efforts to provide comprehensive information and support for early detection and management, especially for clinicians?

*Dr. Hacker. I don't know if that is on.

So while I cannot comment on pending legislation, I will say that I think the strategies around type 1 diabetes and early intervention really speaks to our centers' focus not only on preventing disease, but also on helping early intervention, because, as you said, diabetes type 1 is not known to be preventable at this point. But obviously, strong management with insulin and regularly monitored insulin levels can be extremely helpful in terms of preventing future problems.

*Mr. Joyce. And those future problems, which you elicited earlier and talked about, the renal effects, the kidney effects, the ophthalmologic effect, the effect on the eye and early blindness, that is what this piece of legislation is working to do, to develop an ability to recognize type 1 diabetes early and to prevent those terrible sequelae that so many type 1 diabetics have to deal with. This is a piece of legislation, a bipartisan piece of legislation, that I think would answer some of the questions that you have raised to us.

Mr. Chairman, my time has expired. I thank all of our

witnesses for being present with us here today, and I yield back.

*Mr. Bucshon. The gentleman yields back. I recognize Mr. Griffith, five minutes.

*Mr. Griffith. Is this microphone working? I will shift.

*Mr. Bucshon. You will have to shift, yes. I don't know why your -- we do want to hear what you have to say.

[Laughter.]

*Mr. Griffith. I am shifting to the left, I don't know about that.

[Laughter.]

*Mr. Griffith. Is this one working?

All right. Well, this is one way to build up seniority.

[Laughter.]

*Mr. Bucshon. Your five minutes has expired.

[Laughter.]

*Mr. Bucshon. No --

*Mr. Griffith. I am --

*Mr. Bucshon. I recognize Mr. Griffith, five minutes.

*Mr. Griffith. I am told we are working on redoing this

committee and getting things fixed. All right -- or this committee room.

Dr. Walke, during a recent Covid Select Committee hearing Dr. Fauci attributed the six-foot social distancing rule entirely to the CDC. Four years later, it is still unclear who at the agency created that guidance, what process for development was like, and how it was intended to evolve with new information. Did the CDC ever revisit and reassess the six-foot recommendation, and do you all still stand behind it?

*Dr. Walke. Yes, thank you for the question. During COVID we used a number of different strategies to try to prevent transmission, including testing, including ventilation, distancing, for example, and masking, of course, during that time. So we had some early flu data, for example, that showed that -- the effectiveness of distancing. The actual scientific studies that would undermine that, I would have to get back to you with those scientific studies.

*Mr. Griffith. All right, I would appreciate if you would do that.

Dr. Jernigan, I am switching to bird flu. Does the CDC

think that bird flu or avian flu is likely to become a human pandemic?

You are going to defer?

*Dr. Jernigan. Well, that is -- it is in Dr. Daskalakis's --

*Mr. Griffith. All right.

*Dr. Jernigan. -- center.

*Dr. Daskalakis. Thank you for that question.

So CDC's surveillance systems are key in being able to track seasonal influenza, as well as novel influenza strains that we watch closely for the potential -- for any change that would make us more concerned for human spread. We currently assess the risk to the general population to be low, but have ongoing concerns for people who have exposures like those who are working with animals with known infection. We monitor infections, transmissions to humans, and the way the virus is evolving specifically to make sure that we don't see anything that makes us more concerned.

Highly pathogenic avian influenza is a virus that we have been tracking -- or H5N1 -- for 20 years, and have had a high level of concern, monitoring it very closely. And so

our surveillance systems, the way they are overlapping, both our general surveillance system as well as the specific work that is happening with farm workers is really around the fact that we always have a level of concern that a novel flu could change, and that it could potentially result in more efficient human transmission.

*Mr. Griffith. So translating that into English --

*Dr. Daskalakis. Certainly.

*Mr. Griffith. -- for the folks back home --

*Dr. Daskalakis. Yes, so --

*Mr. Griffith. -- maybe, we don't think so, but we are keeping an eye on it.

*Dr. Daskalakis. We are watching it.

*Mr. Griffith. There you go.

*Dr. Daskalakis. So the bottom line is that our main goal is to keep our fingers on the pulse.

*Mr. Griffith. Now let me go to my next line of questions, since I have got the expert now.

A recent New York Times article reported that only about 60 people have been tested for avian flu, while over 157 herds in 13 states have been infected with this particular

virus. Here is my concern. We are not testing asymptomatic people. I know that a lot of the farmers are concerned that people will think, oh my gosh, you know, this is a horrible thing. But I think if we get more information and more data points now, we may find that there is a lot of people who are getting the virus, they are asymptomatic, and studying the DNA of those people who are asymptomatic or have such mild cases that they aren't necessarily showing up in a doctor's office and getting tested would give us more data, should there be a mutation later that makes it more deadly or more contagious for humans. And we are not doing anything, as I understand it.

Am I correct in that, that we are not looking for asymptomatic people who may work with the same herds that somebody who has gotten sick with? If they are not reporting symptoms, we are not testing them, right?

*Dr. Daskalakis. Thanks for that question.

*Mr. Griffith. Yes.

*Dr. Daskalakis. Actually, we have just released data around a study looking at individuals who are working closely with dairy cows in Michigan. So a special thanks to Michigan

Department of Health for the great collaboration. What we did there is we surveyed those individuals, learned what their exposures were on the farm, but then also drew blood to look for evidence of exposure to avian influenza in their blood. We tested 35 people in that situation, and none of them demonstrated evidence of avian influenza infection, really supporting the plan of testing individuals with symptoms.

I will also add our influenza systems that we have for seasonal flu have actually tested 32,000 people since March using an algorithm that would detect H5N1 in the general population. So we have this targeted testing based on exposure, and then this sort of seasonal surveillance that also looks for these --

*Mr. Griffith. All right. In the seasonal surveillance --

*Dr. Daskalakis. Yes.

*Mr. Griffith. -- are you seeing any upticks in particular regions?

*Dr. Daskalakis. Great question. So we have a lot of overlapping systems. We look at syndromic surveillance, so

what is happening in the emergency departments. We look at percent positivity of testing. And looking across those we see nothing that is a signal beyond what we would expect this time of year.

*Mr. Griffith. And the reason that I ask is because I am particularly focused on the avian flu. We had that one death, I believe, in Mexico, and I am just trying to make sure that we are not seeing, like we did with COVID, that there is a regional variation that suddenly explodes. And the more we can do, the better. It sounds like you are working on it, and I appreciate that.

And I yield back, Mr. Chairman.

*Dr. Daskalakis. Thank you.

*Mr. Bucshon. The gentleman yields back. I recognize Mr. Crenshaw, five minutes.

*Mr. Crenshaw. Thank you, Mr. Chairman.

So I want to focus on the CDC's role and the notion that it is doing -- trying to do too much. I brought this up with the CDC director at our last hearing on the subject. And if you try to do too much, you are -- you end up really doing nothing.

I am not the only one who thinks this. Former FDA Commissioner Scott Gottlieb is calling for a smaller, targeted agency. President Obama's CDC director, Tom Friedman, calling for a culture focused less on publishing academic papers and more on nimble action. That makes a lot of sense to most Americans. I think they view the CDC as the people who go out and quickly address a communicable disease that is new and novel and dangerous. That is -- I think that is what Americans think, right? It is supposed to be an operational organization. That is certainly what I believe it should be, and yet there is massive overlap.

The GAO study continues. You know, since 2010 they have been mandated by Congress to annually report on Federal activity duplication. To name a few in the CDC, I mean, the substance abuse elements of the CDC mirror the Substance Abuse and Mental Health Services Administration. So there is a whole administration for that. We have to really ask, why is the CDC doing that?

Chronic disease programs in the CDC parallel similar institutes at the Centers at the National Institutes of Health. Why? What extra benefit is there? We have to be

asking those questions and asking about resource allocation. I would rather the CDC is really good at getting into the field and doing what needs to be done to stop a communicable disease.

It gets worse than that because then the CDC is also publishing things like the Health Equity Guideline [sic] Principles for Inclusive Communication, saying drug users shouldn't be called "drug users,'' they should be called "people who inject drugs.'' A person who relapsed shouldn't be called that, they should be "person who returned to use.'' You can't call somebody a smoker, you have got to call them "people who smoke.'' That is weird. Also, why is anyone spending time on this? Why is anyone at the CDC spending time on speech codes? That forces the public to lose trust in a very important organization.

It keeps going. I mean, there is another document called, "Racism is a Serious Threat to the Public's Health.'' I mean, nobody likes racism. But again, is it a communicable disease? And how so? And if there is structural racism, like, is there a specific structure that the CDC has targeted to stop racism? Anybody? I can't imagine there is. I am

not really sure it is your job.

There has been a lot of calls for the CDC to investigate a gun violence. I will tell you what. There is already an agency that does that full-time. It is called the police. They investigate crimes, they stop gun violence. There is this really crazy data out there, and it goes like this. When there is more police doing their jobs, there is less crime. When there is less police, when they get defunded, there is more crime. I did all your research for you. It is done. It is that simple because we have common sense.

There are things the CDC needs to be doing. And so I want to end on a positive note. One thing I do like that the CDC has talked about is investigating fentanyl wastewater. Now, that is the kind of thing we should be doing. That is in the field, and it is actually focusing on a problem that Americans have. And with that kind of data, you could you could focus on problem areas that are dealing with fentanyl. Love that. So I will end with that question. I suppose it is for Dr. Layden.

Do you have any updates on CDC's inquiry into this area of research, and whether you can do a pilot project testing

it in key areas?

*Dr. Layden. So thanks for the question. I am going to actually yield to my colleague, Allison, Dr. Arwady.

*Mr. Crenshaw. Okay.

*Dr. Arwady. So the Injury Center, a lot of our work related to substance use is about field-driven response. And actually, there have been more. They are called Epi-Aids when states or locals are requesting help on the ground for an urgent public health threat. There have actually been more from the Injury Center than from any of the rest of CDC in the first six months of the year. We have had seven of those responses. One of those was related to looking to understand more about using wastewater to better understand how to respond to the opioid crisis.

I will tell you, it is a space that we are still very much learning in. We don't have the ability at this point, for example, to differentiate between prescribed opioids or illicit opioids. And it is really important, though, that the work of -- the data work related to the --

*Mr. Crenshaw. But you could be -- that is interesting, but so you can specifically detect fentanyl versus OxyContin.

Is that accurate?

*Dr. Arwady. Yes.

*Mr. Crenshaw. Yes, okay.

*Dr. Arwady. So say fentanyl is used appropriately in a hospital situation --

*Mr. Crenshaw. Sure.

*Dr. Arwady. -- that can't be differentiated.

*Mr. Crenshaw. Understood, yes, but you can at least create hotspots of where there is a higher use of fentanyl in the wastewater, right, whether it is legal or illegal.

*Dr. Arwady. So this is exactly what we are looking into, and we have sent teams in the last few months out into communities that are exploring this.

*Mr. Crenshaw. Well --

*Dr. Arwady. It is early technology, but I appreciate your point of needing to make sure that we have the data to understand this problem. And it is the CDC and the Injury Center where the data work to understand the overdose problem lives, and that is why -- part of why CDC --

*Mr. Crenshaw. Well, I appreciate that. I think -- and I bring it up as one of the things the CDC should be doing,

unlike a lot of the other things I mentioned. So I appreciate that.

And I yield back.

*Mr. Bucshon. The gentleman yields back. I recognize Dr. Schrier, five minutes.

*Ms. Schrier. Thank you, Mr. Chairman, and thank you to all the witnesses for convening here and being squished at that table today to discuss all of the emerging issues facing your respective Centers of Disease Control and Prevention centers and specific offices.

I wanted to start just by thanking Dr. Arwady for being here today. She is a fellow pediatrician, leads the CDC's National Center for Injury Prevention and Control which collects data and funds research at nine injury control centers across the country, including the University of Washington in my state, close to my district at Harborview.

Accidental injuries are the leading cause of death among children, including vehicle safety and drowning and gun injuries. So ensuring fiscal year 2025 funding continues for this particular research is critical.

My question is going to go to Dr. Demetre Daskalakis.

Last week CDC confirmed the first H5N1 influenza infections in poultry workers. It is an addition to the dairy farmers since 2022. This particular year could be particularly important in my district, where the Wilcox eggs that we all purchase at Costco come from, if they were ever to be hit by avian flu.

So my question to you is, while the CDC still believes that the risk to humans is low, what would prompt a change in that assessment?

How would any change be communicated to the public?

And then, if there were human-to-human transmission -- because I am remembering this from when my child was a baby -- how close are we to developing, scaling up production of, and distributing a new H5N1 vaccine that could prevent transmission of this variant?

*Dr. Daskalakis. Thank you so much for that question, so I will start by just highlighting how important our core capabilities at CDC are to allow me to actually answer that question.

So the work that we do in the laboratory and the data analytics really allows us to have visibility into what is

happening with this virus and how it is interacting with human health. So we work very closely with our USDA colleagues, but we have both systems through our local health departments to monitor individuals who have been exposed to this infection, and then also through our laboratories to identify any changes that we see in the virus. So that place where epidemiology touches the lab ends up being a critical piece of the core capabilities that we use.

We have these overlapping systems so that we can monitor what is happening with that virus, but it is also the system that we use to look at seasonal flu and what actually leads to the second part of your question. So our seasonal influenza surveillance is what allows us to identify what is circulating in the community. And that also tells us how to better develop seasonal vaccines, but also how to develop vaccines for more urgent or emergent pathogens.

So, as an example, there are two candidate vaccine viruses that exist today because of this system that allow us to have them available in the event that we do need to scale up. This is also a great point of collaboration with agencies, so we work really closely with our ASPR colleagues

who really are focused on the development and the next steps in preparedness to be able to have vaccine available in the event that we see any changes in the epidemiology or virology related to that flu.

So again, all of those systems come together. We are in a preparedness stance and really moving toward, again, better understanding what is happening, and that important view changes --

*Ms. Schrier. I am going to -- I just have to interrupt you for a second because I want to get --

*Dr. Daskalakis. Sure.

*Ms. Schrier. -- to my next question. But just for the record, if you could submit in writing, first of all, how do you detect that if we only screen for flu during, like, during flu season, and this might not be seasonal?

And second, whether you think the mRNA vaccine or the model vaccines we already have would be the jumping-off point. That could be in writing.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. Schrier. I want to just get in a quick question to Dr. Hacker about cigarette smoking, tobacco exposure.

So cigarette smoking itself has trended down among our nation's teenagers. However, nearly one in four high schoolers still use tobacco products. As a pediatrician, I am really concerned about the widespread use of e-cigarettes, which hook them and then later turn them into cigarette smokers, perhaps, and then vaping products, because we don't know what is in that liquid and how that could hurt the lungs. And these have flooded our schools and, of course, gotten kids re-hooked on nicotine.

I was wondering if you could comment about that in 10 seconds, the work you are doing and what we can expect, and you can do that in writing.

*Dr. Hacker. Absolutely. Well, first of all, we share your concern, and we track this very carefully with our youth risk -- our tobacco survey that we do annually. And we work very closely with FDA, as well. We now have a campaign to empower youth to quit smoking, or to stop from the beginning and never to start, to really give out the information that I think is so critical to being able to make sure people

understand exactly the kinds of things that you raised.

*Ms. Schrier. Thank you. I am talking with my son about it.

I yield back.

*Mr. Bucshon. The gentlelady yields back. I now recognize the chair of the full committee, Mrs. Rodgers, five minutes.

*The Chair. Thank you, Mr. Chairman. I wanted to change the topic to bird flu.

I have been in touch with my local public health workers on the ground, and it is their impression that CDC is asking them to significantly expand their current operations in terms of testing, surveillance, and prevention programs, including wastewater surveillance work and seasonal worker vaccine programs.

Dr. Daskalakis, can you provide more details as to what exactly you are requesting of local partners in their response to the recent bird flu outbreaks, and specify which of these requests are mandatory versus voluntary?

*Dr. Daskalakis. Thank you so much for the question.

Again, our relationship with our local health

departments is critical in terms of the work that happens on the ground, and a lot of the work that the health departments are doing are in line with the work that they do for seasonal influenza and preparedness for any events such as bird flu or H5N1.

So really, we have requested that they work closely with their agriculture colleagues, that we work closely with them in terms of the data that we receive from the jurisdiction both on testing percent positivity as well as asyndromic to be able to monitor any sort of changes in what we are seeing with human disease.

We have also asked them to continue seasonal flu laboratory surveillance into the summer so that we can make sure that our surveillance system identifies any circulating H5N1 that may be seen in the population.

Additionally, we are collaborating with them -- and I will defer to Dr. Jernigan on wastewater, but -- on work to expand wastewater so we have a better view of what is happening on the ground. And we already are working with influenza A in the wastewater, which is the sort of more general virus family that H5N1 is a part of, and are really

working to scale that up with them, as well.

*The Chair. Okay, but before you answer would you just also speak to what authority CDC is relying on to mandate states and localities comply?

And are you conditioning funding on compliance with CDC requests?

*Dr. Daskalakis. And so when we -- thank you for that question. So we really work with our state and local health departments as close partners. And the majority of the work that we do do with them are through cooperative agreements. So we really provide the subject matter expertise, and then work with them to identify ways to implement programs on the ground that work best for them in their jurisdiction.

*The Chair. Okay, thank you.

Did you want to add anything?

*Dr. Jernigan. Yes, just briefly. I think, you know, wastewater surveillance is something that through the last four years we have really seen the incredible use of it. It is cross-cutting, it allows us to look at any pathogen. It makes it able to ready -- ready to respond.

It is all supported with supplemental funding right now.

There is not a budget for it. And so although we have seen incredible gains, incredible use of it across different pathogens and for different reasons, it will go away without any additional funding.

*The Chair. Okay. Okay, thank you.

Dr. Arwady, I have some serious concerns with CDC guidances being used politically or politically influenced and motivated. I have read a bit about your experience as a Chicago Public Health Commissioner, and was concerned to hear how you were treated. It is my understanding that you were fired from your role by -- for trying to open schools for our kids. And I especially enjoyed the anecdote of you locking out virtual classrooms to try and force teachers back to in-person learning.

So tell me, what prevented you from opening schools earlier?

I know that it -- you know, it still took Chicago over 500 days to open schools. Not until August of 2021. And we are still seeing negative impacts these school closures had on kids. So were you pressured by the teachers union to keep schools closed?

And without this influence, would you have recommended schools opening earlier?

*Dr. Arwady. So I remain incredibly proud of my team in Chicago and the work that we did during the pandemic.

I will note that school decisions, as you know, tend to be made at state and then supplemented at local levels. My role leading the Chicago Department of Public Health through the pandemic was to provide the evidence, and that is what we stuck to. We shared when we had, for example, in Chicago, we had the largest private school system in the country was operating with a lot of special protections in place, and our public school system had elected not to return yet in person.

We worked closely. We heard concerns, for example, that Chicago Teachers Union members had not had the chance to be vaccinated. And so as soon as there was an opportunity to vaccinate, we prioritized teachers and others who worked in schools for vaccination, and then worked together to bring kids back into the learning environment.

*The Chair. Okay, I have some more questions on that but I also want to get one more question in for everyone, because we sit here as Members of Congress in control of the

purse strings. And yet I will be the first to admit the disease and program-specific directed funding through the appropriations process has, in my opinion, gotten completely out of control, especially for an agency that remains unauthorized: the CDC. For example, in fiscal year 1990, the appropriations report contained specific funding levels for 18 CDC-related programs. In fiscal year 2023, it included more than 140 line items. So it makes it very difficult to see where the funding is going.

So I do want to follow up in writing with a question for each one of you. I want to know how much funding does your center or office control?

How much of this goes towards grant or support external activities versus supporting internal CDC research and work?

How many staff does your center or office employ?

And how many of your staff could be immediately deployed in a crisis?

And I know we have limited time today, so you can get me those numbers in writing later, and I appreciate you all being here.

[The information follows:]

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*The Chair. I yield back.

*Mr. Bucshon. The gentlelady yields back. I now recognize Ms. Barragan for five minutes.

*Ms. Barragan. Thank you, Mr. Chairman.

Since we are talking about schools and COVID and money, I just want to remind the American people it was actually Democrats who provided more than $122 billion in funding to ensure K through 12 schools could open safely after COVID, and not a single Republican voted for it. So I just wanted to put that on the record.

I want to thank all our witnesses for being here today and for the work that your centers do. The Centers for Disease Control and Prevention, or the CDC, has played a critical role to protect our nation's health from both infectious and chronic diseases since the 1950s.

Dr. Jernigan, I want to start with you. I want to ask you about a program at the CDC that is the Climate and Health Program. Republicans have proposed to eliminate funds for the Climate and Health Program. It is a $10 million cut below the 2024 level, and a $20 million below the 2025 request.

Now, California has faced public health impacts from wildfire smoke and extreme heat driven by the climate crisis, and we have seen similar environmental hazards, harms to communities across the country. Can you speak to how these environmental threats, whether it be wildfire smoke, extreme heat, or floods affect public health and worsen the spread of infectious diseases?

*Dr. Jernigan. Thanks very much. And with regard to the specific program, Dr. Bernstein and the National Center for Environmental Health is -- who is not with us today -- would be the best to respond to that specific question.

But, you know, CDC is a health protection agency. And for me, in addressing emerging and zoonotic infectious diseases, I take into account multiple factors that contribute to the infectious disease threats that Americans face. The impact of weather is one of those factors. Flooding, loss of power from storms, elevated temperatures, these and other factors all contribute to infectious disease transmission, and we in our center are really looking at those consequences of climate.

We are seeing that warmer and wetter conditions really

support mosquito and tick breeding. That increases the chances for Americans to be infected with dengue, with West Nile virus, with Lyme disease, and other things. We also see increases in harmful algal blooms in waters in multiple states in the United States, and then also problems with certain kinds of bacteria that grow in warmer waters, as well, that may affect shellfish. So all of those things are factors that we look into as the world really is more crowded, it is more connected. The animals' and humans' worlds are converging, and climate is one of those components that is helping to see some of those infectious diseases increase.

*Ms. Barragan. So you talked a little about some of these -- what to look for, and some of the things that are happening. Can you talk a little bit about some of the ways that the CDC supports states to combat the rise of infectious disease in unstable climates?

*Dr. Jernigan. Yes. So just to speak to what we in our center do, we have a longstanding support for vector control. Those dollars, about $26 million, go out through the Epidemiology and Laboratory Capacity Cooperative Agreement,

two state health departments, where it helps them to be able to detect -- to pick up insects, find out which ones they are, and see if they are carrying these particular viruses like dengue and West Nile virus. That is how we are monitoring what is happening with the increasing numbers of dengue in the U.S. right now.

*Ms. Schrier. Great, thank you.

Dr. Layden, I have a question for you. The Center for Forecasting and Analytics, or CFA, conducts advanced statistical modeling and analysis for the CDC, with a focus on infectious diseases such as COVID-19 and monkeypox. The Republicans' budget proposes to eliminate funds for CFA. Can you tell us, if CFA was defunded, could you speak to how this would impact local health departments' ability to forecast and respond to disease outbreaks?

*Dr. Layden. So I am going to turn to my colleague, Dr. Walke, because the CFA actually reports to him.

*Ms. Schrier. Okay.

*Dr. Walke. Thank you for the question.

So CFA is the only U.S. Government entity with the primary mission of providing infectious disease forecast

during a response. And since its establishment in 2022, it has been instrumental in advancing public health response forecasting and modeling capabilities for disease outbreaks, has contributed to multiple outbreak responses including polio, acute hepatitis, Mpox, measles, COVID-19, and actually launched Insight Net in September, which is a national network for states and locals to help them build the capacity for modeling and forecasting. CFA was very important for the Chicago response to outbreaks and as well for wastewater surveillance, showing that integrating wastewater data yields a more accurate forecast of hospital admissions for COVID-19.

Reducing funding for or eliminating funding for CFA means that state and locals and the Federal agencies won't have this important capacity to forecast and model in the future.

*Ms. Barragan. Great. It sounds like it is something we should continue to fund. I appreciate it.

I yield back.

*Mr. Carter. [Presiding] The gentlelady yields. The chair recognizes himself for five minutes. How about that?

[Laughter.]

*Mr. Carter. Thank you all for being here, I appreciate it very much. I am very proud to say that the CDC is located in my home state of Georgia, and we are very proud of the work that you do. However, I do have some of what I consider serious questions here.

The Communicable Disease Center, which it was formerly known, was -- the main function, as I understand it, was to predict and protect Americans from infectious disease threats. But it has over time evolved into much more than that. The core mission has been diluted by bureaucracy that is covering now everything from environmental justice to deforestation, firearm deaths, social detriments of health, and a lot more.

For example, Mr. Daskalakis, the National Immunization Survey. The CDC is using taxpayers' dollars to cover -- to call Americans over the phone, asking them for medical information about their vaccination status. In fact, several of my constituents have called me and asked me about this. They have recently received phone calls from the CDC asking them whether they had certain vaccinations or not such as the COVID vaccine.

I understand the importance, trust me, of making sure you have got the information that you need. I get it. But at the same time, it is critical for these agencies to respect the freedoms and the privacy of the Americans. So the first question I have got, Mr. -- Dr., excuse me, Daskalakis, how do you get these phone numbers? Where do you get them from?

*Dr. Daskalakis. Thank you so much for that question.

So I think I cannot actually comment on the algorithm that is used to sort of identify the phone numbers. But the National Immunization Survey, as you have mentioned, is really important in us understanding what coverage is for vaccinations so we can identify what parts of the country and in what populations we need to do more work.

Part of the work at CDC --

*Mr. Carter. I understand, I am just -- and my question is where do you get the phone numbers from? And you say you don't know?

*Dr. Daskalakis. We will have to get back to you.

*Mr. Carter. I was about to say, please get that information to me, okay? Thank you.

How many people has the CDC contacted, do you know, under the National Immunization Survey?

*Dr. Daskalakis. I don't have the numbers of how many people we have contacted, but we can get that, we can get back --

*Mr. Carter. Yes, please. Please do. And do you happen to know how many surveyors that the CDC employs?

*Dr. Daskalakis. Again, we will have to get back to you on those specifics.

*Mr. Carter. Okay. I sure do need to know this, this information.

Does the CDC collect information on children's vaccinations?

*Dr. Daskalakis. The CDC has several systems to monitor vaccination in the U.S. One of them that you have already mentioned is the National Immunization Survey.

*Mr. Carter. Right.

*Dr. Daskalakis. Included in that is a survey that happens to parents specifically to learn more about childhood vaccines.

Additionally, our immunization information --

*Mr. Carter. So do they contact children who --

*Dr. Daskalakis. The CDC -- those surveys are actually for the parents.

*Mr. Carter. So they contact the parents of the children.

*Dr. Daskalakis. Correct. And we also have immunization information systems that really focus on getting vaccination coverage information for parents and from children. It ends up being really critical in terms of the information that children have with their care providers, as well as for their schools.

*Mr. Carter. You know -- and again, can you get me the information about where the phone numbers for the parents of the children come from?

*Dr. Daskalakis. We will follow up.

*Mr. Carter. Thank you, I appreciate that.

Look, as I said before, for better or worse, CDC recommendations and guidance, they carry a lot of weight. They really -- and that -- and I say that as a health care professional, they do carry a lot of weight and they are very important.

So what is the collected information from the National Information Survey used for, and where is this collected information stored?

*Dr. Daskalakis. The National Immunization Survey data is used to report coverage for vaccination in the country. So as an example, during our respiratory virus season, we really brought all of this together in our respiratory vaccine view that shows what coverage is for vaccines such as COVID-19, RSV, all of the seasonal vaccines.

But it is also the information that we use to identify coverage for routine childhood vaccinations such as measles, mumps, rubella, and all of the other vaccines that are recommended.

The information is de-identified, so we actually don't track down to an individual, but only track sort of population trends that we see.

*Mr. Carter. And where do you store it?

*Dr. Daskalakis. Our information is stored at CDC but, again, it is de-identified information.

*Mr. Carter. Okay. So you feel like you are in compliance with HIPAA, so there is no problems there?

*Dr. Daskalakis. Since the information is not identified, we don't have the information that is -- that includes identifiers that would require us to have any sort of HIPAA --

*Mr. Carter. Look, I have a fiscal responsibility to the taxpayers as a Member of Congress, as we all do. Do you feel like this is a good use of taxpayers' money?

*Dr. Daskalakis. Understanding vaccine coverage is critical for us to be able to better advise health care providers and physicians and others in terms of populations that they need to focus on. Being able to see where we have decreases in measles, mumps, rubella outbreak really allows us to use strategies to accelerate catch-up vaccination.

We know, because of the increase in measles, mumps -- or measles outbreaks in the U.S., that populations with lower coverage are the ones that are the most susceptible. So that information is critical for us to really maintain the health of children, as well as adults.

*Mr. Carter. Fair enough. Please do follow up with those answers to those questions. Thank you.

*Dr. Daskalakis. Thank you.

*Mr. Carter. And I will yield back, and at this time the chair recognizes Dr. Harshbarger for her five minutes of questioning.

*Mrs. Harshbarger. Thank you, Mr. Chair. Thank you for the witnesses for being here today.

I want to start with you, Dr. Arwady. As you know, since 1997 some form of the Dickey Amendment has been included in annual appropriation bills enacted by Congress to ensure no funds are made available in funding bills to advocate or promote gun control. How do you ensure that the National Center for Injury Prevention and Control is abiding by this prohibition?

*Dr. Arwady. So the CDC, obviously, does not advocate for or promote gun control policies, and we are in full alignment with that requirement.

The work that the CDC does related to firearms is really to fund the research that helps us better understand deaths and injuries that result. And the kind of research that we fund are things like working with the 4-H shooting clubs across the U.S. that work with kids to say how can we have better firearm safety, or to evaluate things like anonymous

reporting lines in states where high schoolers can call if they have concerns about school violence. Do those sorts of programs work? It is really important that we understand how to help limit deaths and injuries related to firearms. But again, we are in full alignment with the Dickey.

*Mrs. Harshbarger. So I guess my question is, what does your center as a whole contribute to CDC's overarching goal and purpose of preventing infectious disease?

*Dr. Arwady. So CDC's goal is to protect health and improve lives. And the leading causes of death, different than 100 years ago, when it was infectious diseases, is related to non-infectious diseases.

*Mrs. Harshbarger. Okay.

*Dr. Arwady. And so we are focused on preventing the leading causes of death using data, expertise, and resources to --

*Mrs. Harshbarger. Okay. Thank you, ma'am.

Dr. Layden, CDC operates over 100 surveillance systems that collect data on an ongoing basis, often times pulling from state and local departments. I have a series of yes-or-no questions you can just answer.

Does the CDC buy personal information from data brokers, yes or no?

*Dr. Layden. We currently do not have contracts.

*Mrs. Harshbarger. Okay. Does the CDC buy identifiable personal information from data brokers?

*Dr. Layden. To the best of my knowledge, no.

*Mrs. Harshbarger. Does CDC buy identifiable personal information from other sources?

*Dr. Layden. To the best of my knowledge, no.

*Mrs. Harshbarger. Okay. From any source does the CDC buy identifiable health information like vaccine status?

*Dr. Layden. To the best of my knowledge, no.

*Mrs. Harshbarger. From any sources does CDC buy identifiable geolocation information?

*Dr. Layden. We currently do not have contracts for that, no.

*Mrs. Harshbarger. From any sources does the CDC buy identifiable Internet search history information?

*Dr. Layden. To the best of my knowledge, no.

*Mrs. Harshbarger. Does the CDC buy identifiable genetic or biometric information?

*Dr. Layden. No.

*Mrs. Harshbarger. Does the CDC buy identifiable information about children?

*Dr. Layden. To the best of my knowledge, no.

*Mrs. Harshbarger. Will you commit to send me in writing who the CDC buys information from, and any and all types of information the CDC buys, and with each purpose the information is used for?

*Dr. Layden. We are happy to follow up on that.

*Mrs. Harshbarger. Fantastic.

Dr. Hacker, can you explain to me in precise terms how the National Center for Chronic Disease Prevention and Health promotions, focus, mission, and programs differs from those at centers like the NIH such as the National Cancer Institute, with a budget of 7.3 billion; the National Heart, Lung, and Blood Institute, with a budget of 4 billion; the National Institute of Neurological Disorders and Stroke, with the budget of 2.8 billion?

I guess my question to you is what is the CDC doing that is better than these institutions are doing?

And can you explain how your work is not duplicative to

similar work being done at the NIH and across HHS?

*Dr. Hacker. Thank you for that question.

So the CDC and the Centers for Disease Control and Prevention, including, obviously, our center for Chronic Disease Prevention, is really focused on prevention.

And what we are also focused on is taking the information that our colleagues oft times at NIH identify through their research to the field. Eighty percent of our dollars go to state and local health authorities so that they can implement these practices, these evidence-based interventions in the field. And they are really the ones who are actually doing the work. We contribute enormous amounts of technical assistance and support for them, but that is really a lot more of what we do. We are much more focused on the population-based types of things, which is really the perspective on public health, while whereas -- for example, HRSA, which is much more clinical in nature.

And it is very important to combine the public health approach with the clinical approach so that we get that entire spectrum. I think you have heard a lot from my colleagues today about how important it is to understand what

is happening at a population level.

*Mrs. Harshbarger. Yes.

*Dr. Hacker. And our data is also very critical for helping our jurisdictions understand where they have their challenges and where they have their opportunities.

*Mrs. Harshbarger. Yes, it is very interesting when I visited the CDC.

I guess my question is, wouldn't it serve the overarching mission of combating chronic diseases to have everything under one agency is just what I am saying, you know, where we could compile the information and then assess that and use it in a proper way. So that is why I wanted to know what the difference was.

*Dr. Hacker. Well, at this point we work very closely with our sister agencies, but it is also extremely important that our work remains within CDC, where we focused on public health, where we work with the jurisdictions, where we work with our colleagues in infectious disease because we know, for example, that people with chronic diseases are often the most vulnerable --

*Mrs. Harshbarger. Oh, absolutely --

*Dr. Hacker. -- to situations related to epidemics, but also related to natural disasters. And our ability to bring our data to the fore while there, these guys, are focusing on the infectious nature of those conditions, I think actually makes us a more efficient and much more effective organization. As someone earlier said to me, we can chew gum and walk at the same time.

*Mrs. Harshbarger. Well --

*Mr. Guthrie. [Presiding] Thanks.

*Mrs. Harshbarger. Thank you. I will yield back now.

*Mr. Guthrie. Thank you. I appreciate the gentlelady for yielding back. And the chair recognizes Mr. Sarbanes from Maryland for five minutes.

*Mr. Sarbanes. Thanks very much, Mr. Chairman. I want to thank all of you for walking and chewing gum every day because you have tough jobs and you are mission-oriented, and we appreciate that tremendously.

The work that CDC undertakes to prevent, detect, and respond to public health challenges, obviously, is indispensable. And the past few years have given us all a new appreciation for the importance of well-organized, data-

driven collaboration between Federal, state, and local public health agencies, and they have also given us the opportunity, thanks largely to resources that COVID relief legislation provided, to build out our public health infrastructures in ways that reflect both lessons learned and the dynamic needs of the future.

And just on COVID for a moment, we know that the pandemic pushed us to a place of needing to have a greater, broader, deeper, more connected understanding of public health data from around the country. We made some progress there. I think CDC at times lagged behind what some non-governmental entities were able to do in terms of building these data platforms to give us the kind of insight into the trajectory of the pandemic that we would have liked to have, but I know that you are working hard to address these data issues, modernization initiatives to improve data collection, sharing, and interoperability between public health departments at all levels.

So Dr. Layden, could you briefly share the progress you have made on adopting e-reporting, and explain how it is not only helping provide more real-time collection and sharing of

public health data, but also helping to reduce burdens on our health care workforce?

*Dr. Layden. Thanks for that important question, and I am assuming you are talking about electronic case reporting.

*Mr. Sarbanes. Yes.

*Dr. Layden. So electronic case reporting has been one of our great successes with the data modernization effort. Thanks to the funding from Congress, we have been able to invest in this technology across our nation.

Prior to the pandemic, most of the case reports coming to public health were manually entered, typed in, faxed, sent by phone to our health departments. Today we have over 38,000 health care facilities across the nation, across all states that are able to send automated, real-time data through electronic case reporting to our jurisdictions. This saves time, it saves burden on the clinicians and the hospitals, and it gets the data to our health departments faster.

Take, for example, in California. They are leveraging this not just for California, but for a disease called silicosis, sometimes fatal severe lung disease. With the

advent or use of electronic case reporting, they have been able to identify more cases and getting more individuals with this potentially severe disease into treatment.

*Mr. Sarbanes. So I am familiar -- when you are speaking about this, is this the same thing as the Trusted Exchange Framework and Common Agreement, or is that a component of this data collection, this TEFCA? And I know Maryland is a participant in that, they have adopted it. So we would love to hear a little bit more about that, because I know that is data sharing between providers and public health offices and so forth, and curious what you have seen in terms of impact when states like Maryland adopt that.

*Dr. Layden. Yes, we are grateful for Maryland to be an early adopter of a -- really, a game-changer for interoperability between health care and public health.

I mentioned earlier that the Federal Government has invested over $35 billion into health care IT. That pales in comparison to what -- that is so much greater than what we have provided to public health. TEFCA is a Trusted Exchange Framework and Common Agreement which allows data to be exchanged across our national network among clinical and

health care entities, but also with public health. Public health is at the forefront of leveraging this technology. Maryland, as well as eight other jurisdictions, are early adopters. Electronic case reporting is one of the first public health use cases to leverage this technology.

*Mr. Sarbanes. Got it, and I certainly look forward to CDC's continued efforts towards implementing its 2024/2025 goals, particularly those ones that are focused on including additional data sources.

You know, I have been on this committee for a long time. I bring a perspective that the U.S. still doesn't really have a broad, national, robustly interconnected public health system. You find public health systems at different levels of capacity in different jurisdictions, but this notion of knitting it all together in a way that gives us sort of surveillance and all the other kinds of things that we need is still something we are reaching for. I am glad to hear these initiatives on the part of CDC are helping us in that direction, and I appreciate very much you all being here today.

And I yield back, Mr. Chairman.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair recognizes Mr. Balderson for five minutes for questions.

*Mr. Balderson. Thank you, Mr. Chairman, and thank you all for being here today. My first question is for Dr. Walke.

Thank you and forgive me, I see you down at the very end, but my name tags are a little blocked there. But as we look at recent events such as the COVID-19 pandemic and the monkeypox outbreak and the recent bird flu spread, we must take biosecurity and pandemic preparedness to top national security priority. Many experts have expressed concerns that future pandemics could be increasingly severe. As co-chair of the Pandemic Preparedness Caucus, I am committed to ensuring that we are ready for the future health threats.

The CDC was created to be the nation's lead on infectious disease outbreaks. Dr. Walke, does your office hold regular, staff-wide emergency operating drills, training, or exercises to prepare for future outbreaks or public health emergencies?

*Dr. Walke. Yes we do. Thank you for the question.

Not only -- for with moving forward with past the -- after the COVID epidemic we noticed a number of issues that we needed to improve with -- and through the Moving Forward initiative we made some changes, actually, not only in the way we would respond with our workforce, but also the way internally we would, you know, push our guidance out faster and communicate faster, as well.

So we continue as we improve to continue to try to exercise those SOPs.

*Mr. Balderson. Okay, thank you. Are our states and localities included in these trainings?

*Dr. Walke. Yes, absolutely.

*Mr. Balderson. All right, perfect. Thank you very much. My next question is for Dr. Layden.

Dr. Layden, thank you for being here. On February 3, 2023 a train derailed in East Palestine, Ohio. As an Ohioan and a representative for counties in the nearby areas -- I do not represent the affected area -- this incident is incredibly concerning to me, as it should be for all of us. The CDC arrived in East Palestine three weeks after the train derailment. There is no denying that the derailment spread

toxic chemicals into the air, soil, and local waterways.

While I understand the CDC has been assessing chemical exposures and health impacts after the derailment, I am concerned that not enough attention has been placed on this issue. I would like to know what else is being done to ensure that the health, safety, and potential long-term effects of the derailment are monitored. And we are also -- I mean, it seems like every day or every week we are hearing something else coming out about this derailment. So thank you. If you could, answer that.

*Dr. Layden. Yes. So as someone who has worked at the state and local public health, I share your concerns. These events have a significant impact on our communities.

I am not familiar with that investigation. I am happy to defer to some colleagues if they may, or we can get back to you with additional information.

*Mr. Balderson. Would anybody else like to talk about that, or we can have that information submitted --

*Dr. Walke. Yes --

*Mr. Balderson. Go ahead, Dr. Walke.

*Dr. Walke. Our lead agency, the head of our National

Center for Environmental Health, will be best positioned to answer that question, but we will get back to you.

*Mr. Balderson. Thank you all very much. My next question is for Dr. Jernigan.

It is no secret that -- the serious public distrust in the CDC. We also know that individuals in your position are often aware of illnesses that may lead to pandemics or outbreaks much sooner than the general public. This is something that comes with the job, but also requires adequate handling of such sensitive information. During the COVID-19 pandemic there was a lack of transparency and honest communication with the public.

I understand that communications with the public have been acknowledged through the Moving Forward initiative. However, I am not convinced that this is enough. What are some lessons that we have learned about the importance of transparency and honest communications with the public during the COVID-19 pandemic, and that your center will prioritize?

*Dr. Jernigan. Thanks very much.

In our center -- it is the National Center for Emerging Zoonotic Infectious Diseases, but I have been at CDC for

almost 30 years doing mostly infectious disease epidemiology and outbreak control. And COVID was a humbling event for all of us. I think, you know, coming out of that we have really changed how we are doing business.

And in addressing the public's trust, you know, we are focused on, like you mentioned already, transparency, where people need to see both how and why we develop evidence-based public health recommendations that -- we also learned that we need to be listening. We need to better understand where people are, and how we can meet them where they are with public health recommendations.

You mentioned also that -- clearer communication. We absolutely have to communicate the uncertainty that is happening at that situation, and work with the public to get the most understandable recommendations for protecting Americans from infectious threats.

And then finally, I think a big lesson learned was that we have to work together, that we can't do this alone, that the community needs to have better participation in the process, and we need to work with clinicians, stakeholders, and others to fight infectious diseases together because we

just -- we can't do this alone.

*Mr. Balderson. Okay, thank you very much.

Mr. Chairman, I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back and the chair recognizes Ms. Kelly from Illinois for five minutes.

*Ms. Kelly. Thank you, Chair Guthrie and Ranking Member Eshoo, for holding today's important hearing.

Before I start I just wanted to say, Dr. Arwady, it is so great to see you, and thank you for your leadership and the leadership of Mayor Lightfoot for getting Chicago through COVID. So thank you so much.

CDC's mission is dedicated to improving public health as it focuses on our nation's gravest health threats: everything from tuberculosis and influenza to lung and heart disease to opioid overdoses and extreme heat. It is critically important that we ensure the CDC has the necessary resources and funds to address the root problems causing many of our nation's most serious health threats.

We should not cut CDC funding. Instead, we should be making investments in the health of our nation. It pays

dividends, resulting in lower health care costs, better national security and readiness, and a healthier nation. For example, eliminating funding for the Office on Smoking and Health puts our children at risk. I have been very vocal about supporting a menthol cigarette ban to save lives and prevent a new generation from becoming tobacco users. States rely on this funding to keep kids from starting to smoke and vape. This decision would increase health disparities and reverse decades of work done by Congress and the public health community to reduce the harm from tobacco projects -- products.

Dr. Hacker, are there proven ways to reduce tobacco use in the United States?

And if so, what does CDC do in that space?

*Dr. Hacker. Thank you so much for that question.

We have had enormous success in terms of both cessation and prevention from people who -- to begin start smoking with so much of what we have been doing over the last years. I think we have reduced it by 65 percent. But with that said, there is still a lot of work to be done, and we are very concerned about youth vaping in particular and about getting

people the tools that they need to stop smoking if they would like to do so.

Our current Tips for Tobacco -- excuse me, Tips From Former Smokers campaign has been really successful. We have seen over a million people actually quit smoking as a result of that campaign. But we also are doing enormous amounts of surveillance to identify what is going on, what are the current trends, what are the emerging trends, what are the new products that are coming out, and how -- what is the uptake of that, particularly where youth is concerned because a new vaping implement, a new strategy, suddenly it just takes off like wildfire, and we need to be able to be ahead of that.

We work so closely with our colleagues at FDA to understand what they are doing, and recently we have put out grants around education, around menthol, as well.

*Ms. Kelly. Thank you. And what would happen if this program was eliminated both nationally and on the state level?

*Dr. Hacker. Well, all of those things would disappear. We would have no ability to really monitor what was going on

in terms of tobacco use. We would not be able to be doing the activities we are doing with young people around vaping or tobacco use of any type. We would end all of our activities related to the campaign that I mentioned earlier, all of the focus that we now are putting on cessation and particular, which is so critical.

And the bottom line is we would be taking away an enormous amount of resources from our states, because all the states are funded, in fact, to participate and to do this type of work.

*Ms. Kelly. Thank you. As the co-chair of the Bipartisan Maternity Care Caucus, I applauded when Dr. Mandy Cohen became CDC director and she announced that one of her key priorities across the agency is how we can support families and children. As she has rightly pointed out, we are a nation that is only as strong to fight off public threats when given a healthy, equitable start to life.

Our lifelong health patterns start when we are young. In fact, experts have shown that our lifelong health is set up in our first 5 to 10 years. So Dr. Hacker, what is CDC and specifically your center doing to support young families,

whether that is supporting a mom through her pregnancy and making sure she has healthy pregnancy and a healthy birth, or that we are making sure that our children have all the support they need to make it through their first year of life?

*Dr. Hacker. Well, in addition to the work that we are doing in the tobacco space for young people, we are putting a lot of our energies into the work around maternal mortality. And we have successfully created an infrastructure which are called the Maternal Mortality Review Committees, where states can actually dig into what happened when there was a maternal death, and that is really significant information when we really try to understand what do we need to do differently.

And I think you know in Illinois, particularly, you all were the first state to actually extend Medicaid postpartum for a year. And now we have 46 other states that have done so in turn.

We also work in schools, and we talked a little bit about the mental health work that we are doing in schools. Plus, we have the Youth Risk Behavior Surveillance System, which is the foremost surveillance system to understand what

is happening in terms of youth behaviors related to health.

*Ms. Kelly. Thank you so much. I want to thank all the directors for being here today. Thank you.

*Mr. Guthrie. Thank you. The gentlelady yields back and the chair recognizes Dr. Miller-Meeks for five minutes for questions.

*Mrs. Miller-Meeks. Okay. I am going to have to use my big girl voice.

[Laughter.]

*Mrs. Miller-Meeks. So thank you, Mr. Chairman, and thank you to the witnesses for testifying before the subcommittee today.

As both a physician and a former public health director, I take public health very seriously and recognize the important role that the CDC and state health departments play in keeping Americans safe, which is why I released a CDC RFI to hundreds of stakeholders requesting feedback on how to sensibly and effectively reform America's leading communicable disease agency. It is also why in 2021, with the release of the funds which were supposed to be related to COVID, I specifically asked for part of that money to go to

local public health, unrestricted funds to fund local public health, not to go into the big CDC infrastructure or go to the myriad of other things.

But as we know, the least amount of money for those COVID funds went to local public health or to public health in general. So it is rich to hear my colleagues talk about the funding for CDC.

And part of this is requesting money on how our funds go and how to reform the agency. Not surprisingly, public trust in the CDC is at an all-time low. And when I am back in my state visiting with my public health directors, our local public health does not have the same bad reputation that CDC now has. During the pandemic much of CDC's guidance did not appear to emanate from data and scientific evidence, but rather from political interest, as the clear communication we saw between the CDC and the American Federation of Teachers on school reopening guidance.

And as we talk about the risk -- and as we talked about here, and my colleagues have talked about -- young people, suicide prevention, depression, did it not occur to anybody in the CDC that closing schools for a long period of time

would have an effect on young people's mental health and the rates of suicide?

However, to the CDC's credit, they recognized the declining public trust, which has led former director Walensky to launch the Moving Forward initiative. This effort included reorganization and requests for sweeping new data collection authorities from Congress. While CDC hasn't been forthcoming to Congress about the reorganization, CDC at least acknowledges the agency faces significant structural and systemic operational challenges, and indicates a central goal to create new internal processes, systems in government to empower leaders, align incentives, and hold CDC accountable.

I believe that one of the main reasons why the CDC has lost so much trust is because it believes that virtually everything in health is public health. Rather, and regardless of how connected the issue is to communicable diseases, which was how the CDC got started, it was the CDC, not the CDC [inaudible].

For example, the Center for Chronic Disease Prevention and Health Promotion awarded roughly $30 million in grants

from 2010 to 2020 to decrease the level of sodium in foods served in government facilities. Now, it may be laudable to reduce the amount of sodium, but is that a function and purview of the CDC?

The center also has multiple programs, such as addressing conditions to improve health action getting further, faster, healthier accelerator plans and REACH -- would fund virtually the same interest groups to examine social determinants of health. And to the point, what have the outcomes been of those programs?

According to the CDC's own data, health accelerator plans and REACH program recipients received roughly 46 million in fiscal year 2022. How this improves actual public health is yet to be determined. How do we define public health? Are we now talking about population or anything that affects the health of a person, an individual is within the realm of public health?

And as a director of the Department of Public Health, people on our state board of public health, State Board of Health, actually asked that question. Even Democrats asked, "Why is the CDC, why is public health engaged in all of these

areas, rather than focused on what should be the main theme, which is communicable infectious diseases?'' And have we lost sight of that? And how to translate the research that the CDC does into actual messaging and implementing programs.

CDC also studies environmental health and operates the Environmental Public Health Tracking Network, which includes the Environmental Justice Dashboard, a system that processes and publishes demographic factors, environmental burdens, socioeconomic conditions, and public health concerns directly related to environmental justice. As someone with two advanced degrees and decades of experience serving patients in clinical care settings, environmental justice is nebulous and all-encompassing.

So my question for each of the program directors: CDC does not -- and you can answer this offline in written, since I am running out of time -- CDC does not have a mission or purpose defined in statute. If Congress were to go down the path of authorizing the CDC overall, we would also want to authorize each of your centers and offices. So if you can, respond in writing.

[The information follows:]

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3089 **********COMMITTEE INSERT**********

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*Mrs. Miller-Meeks. For each of you, what would your mission be -- succinctly, in two to three sentences if you could. Supply that for us because the mission would not be what we currently function as the CDC. We would be able to take real-world evidence, incorporate that into pandemics, infectious disease outbreaks. We would be able to take research and develop a test -- one of which had already been developed at the University of Washington -- and we would be able to respond appropriately, effectively, efficiently, and rapidly with pivoting as the situation changes to pandemics, which is the main purpose of the CDC.

With that, I yield back.

*Mr. Guthrie. The gentlelady yields back, and the chair recognizes the gentlelady from Massachusetts, Mrs. Trahan, for five minutes for questions.

*Mrs. Trahan. Well, thank you. Thank you to the chair and ranking member, and to all of our CDC directors here today.

I think my colleagues have already described extensively the mission of CDC, and the health threats that you all combat day in and day out. I think the agency's

comprehensive approach also focuses on reducing health care costs, boosting economic productivity, and enhancing our readiness. These are critical functions that impact and improve the lives of all Americans, which is why I am deeply concerned that my Republican colleagues have proposed slashing funding for a number of programs and centers at the CDC.

My colleagues across the aisle have justified eliminating the Injury Prevention Center by arguing that opioid overdose prevention efforts are already being handled by SAMHSA. I would argue that CDC's overdose work is distinctive from SAMHSA's but, crucially, complementary.

Dr. Arwady, I would like to hear from you about what the CDC brings to the opioid discussion, and how the proposed cuts would affect your involvement in the broader Federal response to the addiction crisis that has claimed far too many lives. So if the Injury Prevention Center is eliminated, how will that impact the Federal Government's efforts to address the opioid and overdose crisis that we are in?

*Dr. Arwady. Yes, thank you for the question.

As I mentioned at the outset, more than 80 percent of the Injury Center's funding goes back out to states and locals and 84 percent of our opioid funding. Before moving into this role I led the Chicago Department of Public Health, and had the privilege over eight years of working to fight fentanyl and the changing epidemic there, and I will tell you that the Overdose Data to Action Grant that goes to every state in 40 localities, almost $300 million, when we received that in Chicago, it transformed the way our city was able to respond to this crisis. It let us hire epidemiologists, GIS specialists, really be able to understand not just how many overdoses there were broadly, but in a way that protected patient privacy, where in a block by block time of the day, where exactly was the threat? How was that threat changing? We worked with hospitals, the medical examiner to make sure we had data systems for non-fatal and fatal overdose, so we could really track that.

And then importantly, we developed responses. So, for example, there had not been a coordinated way, if someone had suffered a non-fatal overdose, to ensure that they were getting connected to care. And so the health department,

using Overdose Data to Action funding, was able to make sure that after an overdose there is follow-up to -- with the person who has an opportunity to get connected to treatment and to the rest of their family. Part of that work is making sure that folks are seamlessly connected to the individual treatment facilities that SAMHSA, for example, funds in the City of Chicago.

So it is critical that the SAMHSA work of making sure people can get treatment for substance use disorders continues. It really -- I will tell you from my experience, making sure that public health work is at the table with the data, with the expertise, with the ability to coordinate, and with the ability to those resources, what we are doing, finally, is starting to show promise for fighting opioid overdose in this country. And it is so essential that we take an all-of-government approach and do not lose the critical work that this funds across the country.

*Mrs. Trahan. Well, thank you for clarifying that. It is absolutely work that we must continue.

So during the most recent district work period I had the opportunity to join Whip Clark's bipartisan CODEL to Africa.

And there we witnessed the CDC's impactful work on HIV in Tanzania and their contributions to the global efforts to defeat AIDS. The fiscal year 2025 House Labor/HHS appropriation bill completely eliminates funding for the CDC's global HIV/AIDS program.

Dr. Daskalakis -- did I say that right, Daskalakis? Okay, great. How would withdrawing funding at this critical juncture, which -- we are on the brink of eradicating AIDS on the African continent by 2030 -- how would that set us back?

Additionally, as we aim to counter China's growing influence in the region, wouldn't it be both irresponsible and detrimental to the United States' interests to pull support from programs that have made such a tangible difference in people's lives?

*Dr. Daskalakis. Thank you for that question. I will just start and then say we will also connect you with the center directors that focus on the global HIV program.

But having had a long history of working in HIV myself, I think it is really critical to say that resources really do demonstrate a return on investment, not only for HIV itself, but also for the infrastructure that is necessary on the

African continent to respond to other emerging infections.

So again, really, those resources are critical to be able to respond not only to HIV and remembering that, again, we live in a global village, and what happens in Africa touches us in what happens in the U.S. in all of our cities, and not even in our cities, but in the rural parts of the U.S., as well. So really critical for us to sort of remember that.

And again, I will -- we will make sure to follow up with the center that actually does sort of cover the global HIV work. Thank you.

*Mrs. Trahan. Thank you.

I yield back.

*Mr. Guthrie. The gentlelady yields back and the chair recognizes the gentleman from California for five minutes for questions.

*Mr. Obernolte. Thank you. I don't think our mikes are working on this row, so I will --

[Laughter.]

*Mr. Obernolte. Dr. Walke, I was very encouraged to hear you mention mental health as one of the priorities of

your center. I think you and I are in agreement that we have under-invested in mental health in this country, and we are now, unfortunately, reaping the consequences of that in the forms of homelessness, substance abuse, and all of the different concomitant societal problems with that.

I chair the House Artificial Intelligence Task Force, and health care in general is one of the areas that we see AI having the biggest impact on. But there hasn't been a lot of discussion about AI's impact on mental health, and I actually think that in the future it could have a transformational effect on that. Has the CDC done any investigation or thinking about the impact that AI could have on mental health?

*Dr. Walke. Thank you for the question, and CDC is doing a lot of work related to AI.

I want to defer to my colleague first, Dr. Layden, to talk about AI, and then potentially Dr. Hacker or Dr. Arwady to follow up on the mental health piece.

*Dr. Layden. Yes, thanks for the important question, and I will speak to AI. And then, as mentioned, I will yield to my colleague.

So AI, I agree with you, offers tremendous opportunity and potential. But we also need to ensure that we do this in a way that is coupled with ways to do it in a trustworthy way and to eliminate biases.

CDC has been working to build up AI capabilities, including the development of guidance, addressing security aspects related to it. With investment in AI funds to public health we can start to see the actual use of this technology to support some of the public health mission, as well as the operation aspect of it.

But specifically to a programmatic area, Dr. Arwady, is there anything that you wanted to chime in on?

*Dr. Arwady. I will just briefly add that we agree that making sure we are focusing on mental health, and particularly as it relates to suicide crises, overdose crises, is central.

I will also note that we have to think about prevention in this space, just like we do on the physical side. My center focuses on preventing adverse childhood experiences. Those are experiences that can be traumatic for kids under 18, things like experiencing or witnessing abuse or neglect.

And if we were able to prevent adverse childhood experiences in this country, we would prevent 44 percent of adult depression diagnoses.

We are never going to treat our way one at a time out of this crisis, and so I think the work of public health that is community-based and focuses on prevention and building those structures upstream is critical. And again, we have got to work across government.

*Mr. Obernolte. Sure. Well, you know, it is interesting that the conversation now has turned to prevention because I think that AI could be a huge tool for helping us prevent some of the childhood experiences that are so damaging that you are talking about: online bullying, the negative impacts of social media. I think all of those are things that we could do a much better job at policing. So thank you.

Dr. Walke, I am going to take it back to you. The last year coming out of COVID, the CDC did some introspection about how to refocus the organization on your core mission. And in April you started writing a report on what could be done to accomplish that, and which -- the report came out in

August last year. "CDC Moving Forward'' was the title. I have seen a summary of the report, but I actually have not read the report, and it doesn't appear to me that the report is publicly available. Is that correct, or is there somewhere that we can go to see the contents of that report?

*Dr. Walke. On our website we actually can. It goes through all the elements of the report, all the elements of Moving Forward and what we have been doing in terms of advancing those challenges that were identified and the progress that we have made.

*Mr. Obernolte. Okay. So is there -- I saw that. It didn't seem to me like that was anything more than a summary. But you are saying that that is all the detail of the report?

*Dr. Walke. We had a detailed report. I believe that is also available. I will circle back and make sure that you are able to access that.

*Mr. Obernolte. Okay, okay, I would appreciate that.

So my understanding from reading the summary is that one of the key findings was that organizational silos within the CDC needed to be broken down to refocus the CDC on its core mission. Have you made any progress with that?

*Dr. Walke. You know, in the reorganization we did create these offices, cross-cutting offices, including my own Office of Readiness and Response, and we created the data office that Dr. Layden here is leading, and also a cross-cutting office related to and center related to laboratory quality and laboratory support.

So yes, we at CDC -- and Moving Forward pointed out -- we did have a series of silos, actually, within the organization, and we saw with COVID we needed to bring the whole organization actually to the fight. And so after COVID and with Moving Forward, we identified where the issues were, saw that across multiple CIOs, or centers and institutes, there were opportunities, really, to standardize the way we were working, including on the workforce which we have talked about as the CDC ready responders, so it is not just a small group of people responding to every outbreak, but actually all 12,000 strong at CDC can respond and fit into an emergency operation center, as well as to an incident management system.

*Mr. Guthrie. I haven't asked questions yet, so --

*Mr. Obernolte. Well, thanks for your response, and I

look forward to following up on that.

I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back and I will recognize myself for five minutes for questions. So thank you all for being here. It has been -- I am appreciative of what you guys do. And this first question is for Dr. Jernigan. Director Cohen has communicated and communicated well about the avian bird flu. But I would say it is a concern that we all have. And I want to ask Dr. Jernigan about a specific point in the HHS action plan to address avian flu.

They wrote in May a quote, "addressed the manufacturer issue detected with current avian flu test kits.'' And boy, we don't want to hear that again. That rings true of 2020. Could you talk about what issues were detected with flu test kits?

*Dr. Jernigan. Yes.

*Mr. Guthrie. And has the issue been addressed?

*Dr. Jernigan. Yes, so I will yield --

*Mr. Guthrie. Was that Dr. Arwady or Dr. Daskalakis?

*Dr. Jernigan. Daskalakis.

*Mr. Guthrie. Daskalakis, yes.

*Dr. Daskalakis. Thank you for the question.

I will start by saying that it is the sort of quality systems that grew from the experiences in COVID that actually were able to detect an issue, a manufacturing issue with the test. Very importantly, the test, with its manufacturing issue, does not have any propensity towards false negatives or false positives. And in close collaboration with the FDA we know that the tests that are out in the world are actually very usable to be able to detect avian influenza.

So I will just go back and say, really, the quality systems that grew from the experience in COVID identified the issue, and we have -- we are resolving the issue. And like I said, the kits that are out --

*Mr. Guthrie. Can you share what the issue is?

*Dr. Daskalakis. Sure. There are three components to the assay, and two of the components work normally, and one of the components sometimes would result in an inconclusive test. Any inconclusive test or positive test on those kits then come back to CDC for confirmation.

So this very rare issue was identified through the

quality systems that we have developed, and all of the tests that happened in the field were ultimately again checked at CDC and confirmed. So that manufacturing issue is being resolved. We are replacing that component in the kit. And again, those tests that are in the field are 100 percent usable, and not prone to false negatives or false positives.

*Mr. Guthrie. So at worst case you would get inconclusive and have to test again.

*Dr. Daskalakis. At worst case there would be inconclusive, and it comes to CDC and then we test it again. So all of -- every inconclusive comes to us for confirmation.

*Mr. Guthrie. Okay, thanks. So I have Dr. Jernigan down as the person to ask, but maybe you, Dr. Daskalakis. So the infrastructure, hopefully we don't get to human-to-human contact with avian flu. Could you kind of give an update with avian flu, where we are?

*Dr. Daskalakis. Sure.

*Mr. Guthrie. And then, is the testing structure in place to distribute quicker than -- since we have tests?

*Dr. Daskalakis. Great, thank you.

So in terms of where we are with avian flu from the

human disease side, to date we have identified 10 confirmed infections since April, when we first detected the infection.

*Mr. Guthrie. And they are not human to human?

*Dr. Daskalakis. No.

*Mr. Guthrie. Okay.

*Dr. Daskalakis. So we are not seeing any evidence of human-to-human transmission. All of the cases were individuals who had exposure to either infected cows or poultry.

We are working in multiple domains to make sure that testing is available and adequate. So through our public health labs testing is available at this point. Again, that is -- that capacity exists, and it is really being flexed now as we are identifying individuals with symptoms.

Additionally, we are working with commercial laboratories to be able to move this testing also into the commercial arena in time for when we hit our regular flu season so that clinicians and public health practitioners will be able to differentiate seasonal influenza from age five.

So all of those are happening simultaneously.

*Mr. Guthrie. So what is your threat level or level of concern? I hate to just say 1 to 10 --

*Dr. Daskalakis. Great question.

*Mr. Guthrie. I don't want to do that, but I want you -- because I don't think that is fair. But what is the --

*Dr. Daskalakis. I will call --

*Mr. Guthrie. What is your level of concern?

*Dr. Daskalakis. In terms of what we are concerned for the general population, we think that the risk for the general population is low. But we have increased vigilance around individuals who have exposure to infected animals, whether they be cows or poultry.

*Mr. Guthrie. Okay, thanks.

And Dr. Arwady, I guess getting back to the SAMHSA versus what is going on at CDC, so your work is additive. I mean, what is the difference in your work, and why is your work additive and not duplicative? That is the question.

*Dr. Arwady. Yes, thanks. So we work very closely, of course, with SAMHSA. We actually fund different entities, even.

The CDC funds public health departments; SAMHSA

primarily funds state behavioral health and mental health agencies that are ensuring that people can get that clinical care.

The CDC is focused on the data piece, like I have said a few times, in terms of making sure that we have day-by-day information for how this threat is also changing, and it is. We also work to make sure that that data is then shared with our partners, whether it is at SAMHSA, whether it is at NIDA, across the agency.

And finally, we work on things like making sure public health departments will work to connect individuals to the care that SAMHSA provides, and we will work to make sure that we have the data to know that naloxone, for example, the reversal agent that SAMHSA is providing, is in the right places in communities.

So those are just some examples, but these are not duplicative. I want to be really clear about that. They are complementary, and we work really closely together to be sure of that.

*Mr. Guthrie. Well, thank you. And my time has expired and I will yield back.

Dr. Walke, I think you were ready to grab the microphone to talk, but I time is expired, and I will yield back. And I believe that concludes all members who are present to ask questions, and so we will conclude with questions. Thank you all very much. We are not done yet, but we are concluded with questions. A few more seconds.

And so I have a list for documents for the record, and I ask unanimous consent to insert in the record the documents included on the staff hearing documents list.

*Ms. Eshoo. Without objection, Mr. Chairman.

*Mr. Guthrie. Without objection, that will be in order.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. And I will remind members that they have 10 business days to submit questions for the record, and I ask the witnesses to respond to questions promptly. And members should submit their questions by the close of business on August the 6th.

Again, thank you so much. Thank you so much for being here. Thank you for the information. It was a really good hearing, and we appreciate you being here.

And without objection, the subcommittee will be adjourned.

[Whereupon, at 2:10 p.m., the subcommittee was adjourned.]